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Between Ourselves

For a somewhat more optimistic note on the general nursing scene in one large part of Canada, we commend to you our guest editorial written by the president of the Alberta Association of Registered Nurses — **Blanche Annie Emerson.** When she retired from active duty two years ago, Miss Emerson accepted the presidency of the provincial association because she was vitally interested in nursing matters and felt she might have more free time to devote to the demands made upon this office. Little did she foresee that she would again be called back into active duty. Yet today she is acting director of the nursing service of the Alberta Department of Public Health.

Following graduation from the Hamilton General Hospital in 1909, Miss Emerson engaged in private duty until she enlisted with the C.A.M.C. in 1918. Soon after war's end she enrolled in the public health nursing course at the University of Alberta. Her work in the Child Welfare Division of the Alberta Department of Public Health made her well known to countless hundreds of perplexed mothers. Latterly, she has continued to reach them through regular radio chats. Miss Emerson is interested in music, books, walking, camping, but most of all, in people.

Every now and then, we have an opportunity of bringing you an extra special bit of information. The feature article describing the artificial kidney by **Dr. John MacLean** is one of these "specials." So far, the apparatus is only being used in two Canadian centres — the Royal Victoria Hospital, Montreal, and the Toronto General Hospital. As its use is extended further, more nurses will have the opportunity of observing it in operation. In the meantime, this excellent word picture will inform you of how it works, the conditions for which it is used, and what the results in patient well-being are.

There is general agreement, in theory, that every nurse should have a sound basic knowledge of **modern public health practices,** of the value of the various preventive procedures such as immunization, of the psychology of normal human behavior, of the essential nutrition of the well child or adult. Somehow all of this is supposed to be integrated into the lectures of the student nurses so that, upon graduating, they can teach parents the so-called "laws of health," etc. A special committee which was set up by the Registered Nurses' Association of Ontario spent many months studying these and associated problems. Their findings would indicate that we still have a long way to go before nurses are truly health conscious. Their results also showed that the inclusion of a public health nurse on the school of nursing faculty is not necessarily the answer.

How many of your immediate friends or associates wear spectacles? It is not at all unusual to find that half of any group have some degree of correction for defective vision. We are aware of the defect because of the glasses. No such indicator points out those with **defective hearing.** We may observe a certain amount of tenseness, a straining to catch what is being said. Because it is less obvious, the child who is hard of hearing labors under a serious handicap. While knowledge of the routine tests for hearing are of little importance to the general nurse, an understanding of the problem that exists and of the means that are available to assist these children is essential. Much misery and frustration can be prevented if the defect is detected early, even before the child starts to school. Every nurse can assist here.

Recent studies indicate that androgenic treatment may be of considerable therapeutic value in angina pectoris. This use of male hormone has been reported to reduce the frequency and severity of attacks, to increase exercise tolerance, and to produce a feeling of well-being. In some instances, however, there is gradual recurrence of symptoms on discontinuation of treatment and in a few there is questionable improvement or none whatsoever.

For relief of symptoms, it appears that a minimum of 16 semi-weekly injections of testosterone propionate, 25 mg. each, is advisable. Treatment with testosterone is of no value in the acute attack of angina pectoris when, of course, nitroglycerin is indicated. Testosterone is to be employed as a means of preventing attacks or of reducing their frequency or severity, and is a form of therapy to be used over a relatively long period.

— *Journal of Clinical Endocrinology*

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*West. J. Surg., Obstet. & Gynec., 51:150, 1943; J.A.M.A. 128:490 1945; Am. J. Obst. & Gynec., 48:510, 1944, etc.

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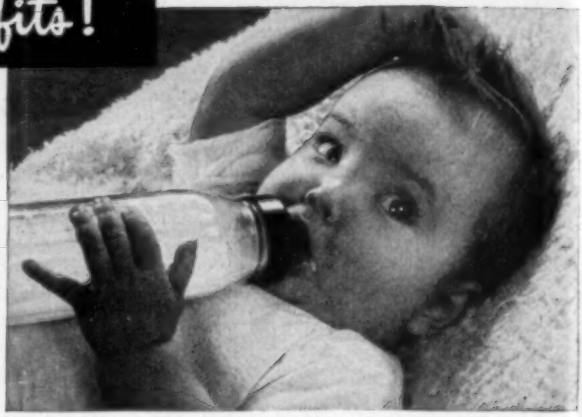

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The
CANADIAN NURSE

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MONTREAL, FEBRUARY, 1949

Brighter Days Ahead

"Will you walk a little faster," said the Whiting to the Snail, "The Porpoise is behind me and is treading on my tail."

DURING THE PAST few years nurses everywhere have been in the position of the poor frustrated Whiting. With so much pressure on every side, they are forced to travel at what seems to them to be a snail's pace. There is no record of what the Snail said to the Whiting in reply, but we are prepared to hazard a guess that it did not move any faster. We are not told what steps the Whiting then took to overcome the treading on his tail that was a source of such distress to him, but we dimly suspect that at the first opportunity he parted company from his slow companion.

As we in Alberta look over the events of the year that has just passed, we realize that much that we had hoped to achieve has not been accomplished. We had dreams of a central school which would help to relieve the shortage of approximately two hundred nurses needed in hospital and public health fields. We hoped for some sort of job analysis which would lead eventually to nurses doing what is strictly nursing duties, leaving all those time-consuming odds and ends of this and that to people suited for less particular lines of endeavor. In our zeal to do a good job, we nurses have acquired the very bad habit of assuming duties that belong anywhere from the kitchen to the hospital office, but are certainly not nursing duties. Take, for example,

BLANCHE EMERSON

the secretarial work that is being done by nurses everywhere both in hospitals and public health. Nurses are not actually good business women. To be strictly truthful, they are the world's worst. Of course, there are exceptions to every rule, and there is the odd nurse who has inherited a certain amount of business acumen, but I repeat, they are the exception rather than the rule, so we see nurses laboriously working over reports and figures that could be done better by far by a well-trained secretary in a quarter of the time.

Meanwhile, services that belong strictly in the nursing field are being performed in many cases by untrained, ignorant women of the Sairey Gamp variety. Many of them are kindly well-intentioned women, but alas! it is a bit disconcerting, to say the least, when your eyes are bandaged following an operation, to hear a ward aide cheerfully say: "And is the soup too hot? Well, I will just blow on it for you, dearie, and it will be all right." It was also a severe shock to one of our prominent nurses a short time ago, when her eighteen-year-old nephew, who intends studying medicine, was doing a spot of work as a hospital orderly during the summer holidays, and came home with some pills rattling in a bottle in his pocket. He said he had neglected to place them on the tray after giving the medicines. His vivid account of the hypodermics he was allowed to give filled her with alarm. He was on night duty, there was only one nurse on the ward. She was very busy, and then she had all the charts and records to keep.

Hospitals were organized primarily for the care of the sick, but in these days of over-organization and so-called efficiency, there is a grave danger of the patient being considered as the person of least importance in the whole set-up. It is up to us, as a profession, to consider ways and means of improving the bedside care that is being given. If having a job analysis would help — then we should see to it that some means of having one made is provided.

However, in spite of not being able to complete all the plans we have made, we can see brighter days ahead. The matter of a central school is still being considered in Alberta, and some spade-work has been done. Under the Dominion Health Grants, impetus has been given to various suggestions, made by the liaison committee of the A.A.R.N. to the Survey Committee, on matters of direct interest to the nursing profession, details of which will be announced later.

Alberta's eleven schools of nursing are crowded and many applicants had to be refused admittance to the classes last September. We are more than pleased with the type of student applying for admission to our schools of nursing. We feel sure that the future of nursing is safe in their hands. The block system is being tried in the Holy Cross Hospital, Calgary, and the general feeling is favourable towards it. As it is only in an experimental stage, it is somewhat early to assess its ultimate value. While we still speak of shortages there are more nurses available for general duty, especially in the large hospitals.

The private duty nurses in Alberta are doing an excellent piece of work in their quiet, unobtrusive way. Recently, we asked the civic authorities to shoulder their share of the responsibility for the upkeep of the Edmonton doctors' and nurses' community registry service. We were proud to know the high regard in which this service is held, and were glad to learn that the city officials were prepared to provide an office and telephone service as their share in the project. The private duty nurse interprets the nursing service to the public, and the service rendered is none the less valuable because the nurse is on her own.

More nurses are now available for rural health units, and for the first time in several years all vacancies have been filled in the district nursing service.

We feel encouraged at the way the institutional, public health, and private duty nurses are working together in all centres in our province. Maybe

it is well that we have these occasions when we have to prove our worth.

The married nurses in Medicine Hat still raise funds to provide special nursing care for acutely ill patients unable to provide it for themselves. This service has been maintained for many years. We think it an example that might well be emulated in other communities.

We shall probably always feel the pressure of the Porpoise and like our friend, the Whiting, become impatient with the Snail that impedes our progress but, from the nurses' point of view, these are wonderful days for the nursing profession, and it is good to be alive and have a share in the developments that are taking place.

BLANCHE A. EMERSON
President
Alberta Association of Registered Nurses

The Use of the Artificial Kidney

JOHN T. MACLEAN, M.D., F.R.S.C. (C.)

AN ARTIFICIAL KIDNEY is a machine designed to take over the function of the human kidney, for a limited period of time, when the latter, either as the result of disease or poisoning, is incapable of excreting the waste products of the body. In 1913 Abel, Rowntree, and Turner carried out successful experiments in animals, with an artificial kidney but the idea could not be applied to humans because of the lack of a safe anti-coagulant, and the unavailability of a suitable dialyzing membrane. These fundamental problems have since been overcome by the introduction of heparin (an excellent anti-coagulant) and cellophane (a suitable dialyzing membrane). During the war years, Kolff working in Holland, and Murray in Toronto, each independently and simultaneously, constructed an "artificial kidney," which was capable of performing the functions of a human kidney for a limited period of time.

Experience with the use of one of these kidneys (Kolff model) has led to the realization that, in properly selected cases, it is truly a life-saving procedure. It is a form of therapy which will come into use increasingly often in hospitals, thus the desire to acquaint you with its possibilities.

Dr. MacLean is assistant urologist, Royal Victoria Hospital, Montreal.

The principle of the machine is simple—namely, that the blood and waste products of the body are on the inside of a cellophane tube and are separated by the cellophane only, from a bath solution on the outside. The difference in osmotic pressure on the two sides of the cellophane tubing (dialyzing membrane) causes the waste products of the blood to pass through the membrane (cellophane) into the bath water. The bath water contains various salts in order to prevent passage of the water into the blood. Further, the tubing containing the blood is wrapped around a wooden drum, and the drum rotated in the water in order to hasten the passage of waste products from one side of the cellophane to the other. The whole process may be represented diagrammatically as per Fig. 1 and the photo.

DESCRIPTION OF THE APPARATUS

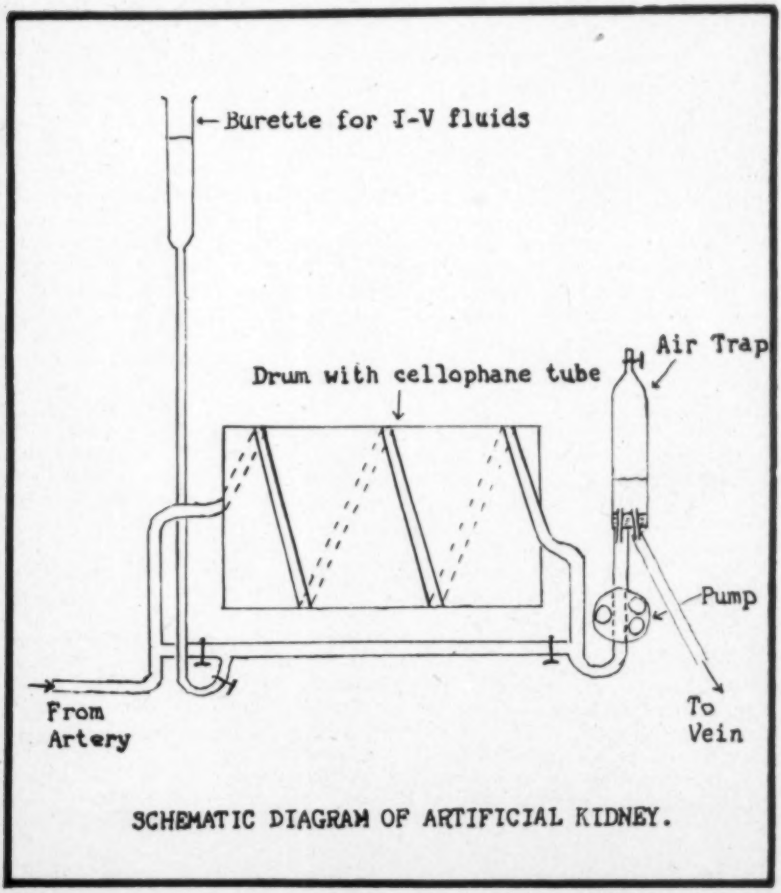
The machine used at the Royal Victoria Hospital, Montreal, was obtained from Dr. W. J. Kolff of Kampen, Holland. Certain modifications have been added to make the apparatus more efficient and easier to control. The artificial kidney consists of a large wooden drum around which 100 feet of cellophane tubing is wound in spiral fashion. This tubing has a flat diameter of 1 inch. The drum revolves at a constant speed of 25 revolutions per minute in a bath

of the following composition: NaCl, 0.6%; KCl, 0.04%; $NaHCO_3$, 0.2%; glucose, 1.5 to 2%; tap water, 100 litres.

The patient's blood enters the cellophane gut from a cannula in the radial artery. The tubing carrying the blood passes on to the drum through a rotating coupling. At the other end, the blood passes through another rotating coupling into an air trap and thence via a glass cannula into a forearm vein. A variable speed pump is provided at this point to facilitate the circulation. The rotary movement of the drum spreads the blood into a thin film on the surface of the cellophane tubing, thus exposing a greater surface area to the bath and requiring only 500 cc. of blood to fill the tubing.

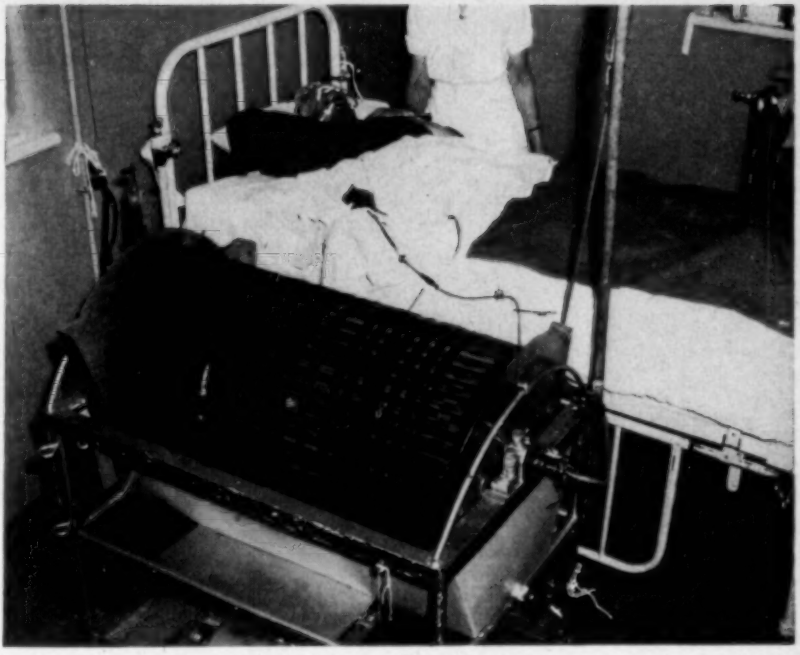
The bath fluid is kept at a constant temperature of 100° F. by a thermostatically controlled heating element. The couplings, the air trap, and the glass and rubber connecting tubes are sterilized by autoclaving and the cellophane is sterilized by boiling. The rest of the apparatus does not have to be sterile (see photo).

The chief clinical value of such an apparatus at present lies in the possibility of treating uremia due to reversible or curable conditions of the kidney. In such cases a temporary clearing of the blood by dialysis may



SCHEMATIC DIAGRAM OF ARTIFICIAL KIDNEY.

FIG. 1



The artificial kidney in operation

prove a life-saving measure. Successful cases have been reported.

The types of uremia in which dialysis may be of value can be listed as follows:

1. *Acute renal lesions with uremia:* (a) Fulminating acute glomerulonephritis; (b) acute poisoning — mercury, phenol, etc.

2. *Lower nephron nephrosis type of lesion:* Anuria following (a) incompatible transfusion; (b) sulfonamide administration; (c) the crush syndrome; (d) severe burns; (e) eclampsia.

3. *To prepare the uremic patient for a surgical procedure:* (a) Prostatic obstruction; (b) infections of the kidney.

Technique of Dialysis

The artificial kidney is set up and 10,000 cc. of sterile saline are run through the tubing as a rinse. The apparatus is then filled with 500 cc. of saline solution containing 150 mgm. of heparin. If the patient is anemic or in poor condition, the tubing can be filled with 500 cc. of heparinized blood.

A blood pressure cuff is wrapped around the patient's arm to be used as a tourniquet in case of hemorrhage. A cut-down is then made on a forearm vein and a glass cannula inserted and connected with a continuous saline drip. The radial artery is next exposed, and after the patient has been given 150 mgm. of heparin intravenously, a glass cannula is inserted into the artery and connected to the artificial kidney. Metal connections and cannulas are avoided for fear of inactivating heparin. The blood traverses the cellophane tubing by the force of arterial pressure, aided by the rotation of the drum, and is returned into the patient's vein by the variable speed pump. Blood or intravenous fluids can be added to the circuit as required and blood samples can be removed at will from arterial or venous tubes. Venipuncture is considered hazardous in the heparinized patient.

During the course of the dialysis the patient's blood is kept liquid by adding 50 mgm. of heparin to the cir-

cuit every one and a half to two hours. We have found that large amounts of heparin are necessary because a significant quantity is lost by dialysis. It is much better to give too much than too little, and in case of severe bleeding protamine sulphate can be used intravenously to neutralize the anti-coagulant effect.

Throughout the procedure the patient is carefully observed and pulse and blood pressure are recorded at frequent intervals. The dialysis is continued from two to ten hours, until the non-protein nitrogen reaches a normal level. The blood non-protein nitrogen and CO_2 combining power are determined at hourly intervals.

Effects of Dialysis on Patient

I. *Blood chemistry*—(a) The non-protein nitrogen decreases at a rate of 10 to 30 mgm. per cent per hour; the bath water non-protein nitrogen increases proportionately. (b) Blood chloride remains constant. (c) Blood calcium tends to fall. This can be prevented by giving the patient 10 gm. of calcium gluconate I-V every three hours. Calcium salts added to the bath water precipitate out. (d) Acid-base balance. There is often a tendency to acidosis which can be counterbalanced by giving 1/6 molar sodium lactate I-V in 500 cc. amounts, when the CO_2 combining power falls below 50. An alternative, though more complicated method, is to bubble CO_2 through the bath under an enclosing hood. (e) Blood sugar rises because the bath water contains a high concentration of glucose to avoid hemolysis. This can be utilized by the patient. In some cases the administration of insulin may be advisable.

II. *Blood morphology*—(a) Coagulation time has remained markedly elevated in all cases because of the large doses of heparin. In Case 2, despite a coagulation time of one hour in the circulating blood, clotting occurred in the cellophane tubing. This emphasizes the fact that heparin is lost by dialysis and large doses are required to keep the blood in a fluid state. (b) Blood cells—the red cells show no change on dialysis and hemolysis does not occur. The white cells undergo an initial fall which is followed in several hours by a return to normal values.

III. *Cardiovascular system*—The artificial kidney acts as an arteriovenous shunt and this imposes an extra strain on the cardiovascular system. To date we have observed no ill effects from this and the patients have stood the dialysis extremely well with little or no change in pulse and blood pressure.

IV. *Subjective changes*—These were impossible to evaluate in Case I who remained comatose throughout and in Case 2 in whom the dialysis was discontinued under one hour. In Case 3 a rather striking change was noted. After three hours the patient volunteered the information that her head felt clear and that the dirty taste in her mouth was gone. This coincided with a drop in her non-protein nitrogen from 102 to 49 mgm. per cent.

V. *Urinary changes*—The urinary output increases as the uremia decreases. This was strikingly shown in Case 3 (Fig. 2). The other urinary constituents did not undergo any apparent change.

Case 3

Patient H.T., female, aged 55, was admitted to the Royal Victoria Hospital on March 12, 1948. She gave a long history of many previous illnesses, including a carcinoma of the thyroid which had been treated by surgery and radiation. Her presenting complaints on admission were abdominal pain, hypertension, nausea and vomiting. A diagnosis of polycystic kidneys with secondary pyonephrosis and uremia was established. Her non-protein nitrogen rose from 88.5 mgm. per cent on March 13 to 159 mgm. per cent on March 15. Cystoscopy and drainage caused a drop to 102 mgm. per cent on March 17. However, her urinary output decreased from 450 to 130 cc. in twenty-four hours, and her symptoms became more marked. She complained of headache, stupor, and a dry dirty taste in her mouth and seemed to be going rapidly downhill. She was connected to the artificial kidney March 17. Dialysis was continued for six hours during which time her non-protein nitrogen dropped to 48.0 mgm. per cent. She

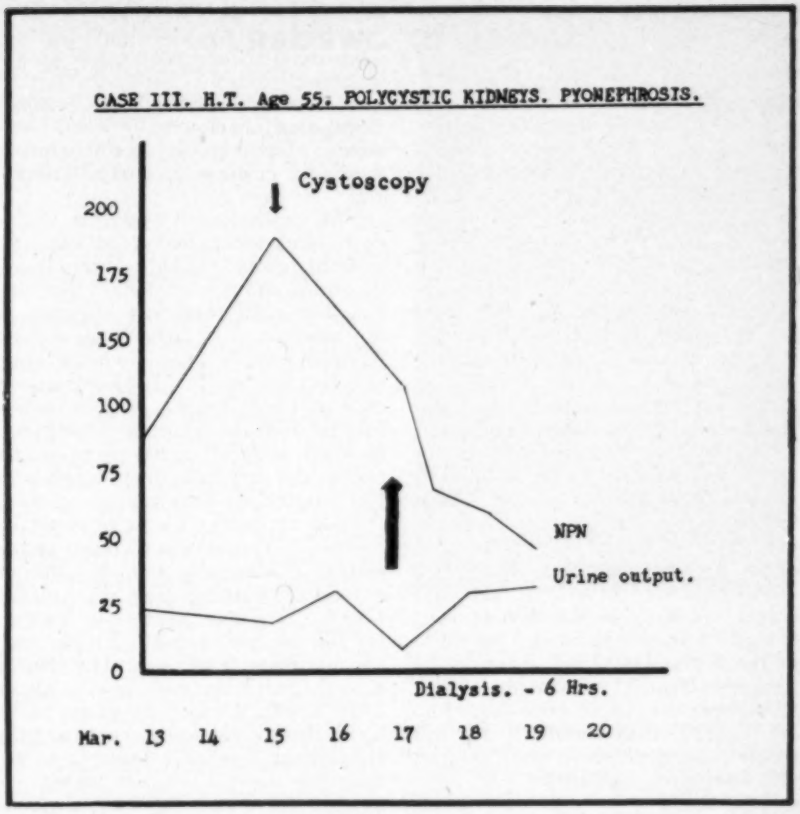


FIG. 2

had a mild acidosis during the procedure, the CO_2 combining power dropping to 30.4. This was corrected with 1000 cc. of 1/6 molar sodium lactate and the CO_2 combining power rose to 48.

The patient tolerated the dialysis extremely well and after three hours volunteered that her head felt clear and the dirty taste was gone from her mouth. Following the treatment she seemed improved and her daily urinary output increased to 600 cc. in 12 hours.

SUMMARY

The artificial kidney appears to be an effective method of removing waste products from the blood in cases of uremia. Its clinical usefulness, in theory, is limited to those patients in whom the renal damage is temporary, or reversible. It provides a means of saving such patients from death, and certainly justifies its existence in any large centre. It is well tolerated by the patient and apparently causes few harmful effects. As an investigative tool the apparatus has a large field. It should prove valuable in studying uremia because some "toxic" factor appears to be removed from the blood and may be present in the filtrate. In addition it is a good method of studying the metabolism of various diffusible substances in the experimental animal and in the human.

Space-saving

During the war the Germans perfected methods of filming 150-word letters on films small enough to fit into the space occupied by a period, formed on a typewriter!

Going to Sweden?

MANY CANADIAN NURSES have indicated their desire to participate in the Congress of the International Council of Nurses in Sweden next June. Few know very much about the country they propose to visit, its points of historical interest, its political picture, its nursing and health facilities, etc. In order to provide reasonably adequate information on the many phases of Swedish life this material is presented. Through the kind assistance of the Minister of Sweden at Ottawa, numerous pamphlets were made available. The interesting photographs accompanying this article were also supplied by him. A series of letters on her trip to Sweden written by Elizabeth Lyster, and published in successive issues of *The Canadian Nurse* in 1942, will give a more intimate picture of life and travel. A story of the development of modern nursing in Sweden appeared in the November, 1948, issue of the *American Journal of Nursing*. From all of these sources, we hope those who are planning their summer's trip will secure a comprehensive impression of this fascinating country.

VISITORS TO SWEDEN

There are not many formalities required for travel to Sweden: only a passport, valid for Sweden (issued by the Department of External Affairs Passport Division in Ottawa) and a visa, obtainable through the Swedish Legation or your local Swedish Consulate. There are no special requirements by customs or health authorities.

You can take into Sweden Canadian bank-notes and coins in any amount, provided the denominations do not exceed twenty dollar bills. You can also take travellers' cheques in any amount. The latter is the recommended way in which to have your money. In Swedish bank-notes and coin, only 99 kronor may be taken into or from the country. One krona is worth approximately twenty-eight cents. All personal effects taken into the country are duty-free.

Food rationing is still in effect in Sweden. Meats of all kinds, sugar, coffee, cooking-fats, and all kinds of soap and washing powders are rationed. However, visitors in Sweden are allowed extra rations. Living costs are no higher than here. The cost of a good hotel room with bath is about $3.00 single. One of the guide-books lists the hotels and restaurants throughout Sweden. There is an interesting use of symbols which enables a traveller to tell at a glance what accommodation the hotel provides. A sixteenth of an inch stove indicates central heating; a tiny bath-tub tells you that private baths are available, etc. In Stockholm it is planned to assign the delegates to

Newly-built municipal hospital in Stockholm

their quarters. Your application should have been made long since. If it hasn't gone you had better rush it off immediately. For post-Congress travel in Sweden you will find that booklet useful as it indicates the places where English is spoken in case you cannot speak Swedish.

Physical Features

Sweden is a country of forests, lakes, and mountains. It is one of the most northerly countries in the world, her southern extremity lying in the same latitude as northern Ireland and Labrador. Her northern regions are closer to the pole than Iceland and parallel to upper Alaska. Sweden is the fourth largest country in Europe with an area of 173,378 square miles, slightly more than one-third of the size of the province of Ontario. Her population is roughly half that of the whole of Canada so that the population density is 43 per square mile compared with our 3.5.

Lakes and rivers abound in this land, the total of the former being placed at 96,000. Though her topography is broken and mountainous, there are extensive plains in the southern part of the country. Thanks to the Gulf Stream sweeping along the west coast of the Scandinavian peninsula, Sweden enjoys a temperate climate. Lappland, the northernmost province, has a winter of seven months and a summer of two months.

Some compensation for the depressing dark winters in the far north, which receives almost no sunlight for about two months, are the summertime's "White Nights," the manifestations of the midnight sun. There are six weeks of continuous daylight above the Arctic Circle which lies 140 miles south of the northern tip of the country. In midsummer, it is possible to read out-of-doors the whole night through as far south as Stockholm.

The People

Like the Anglo-Saxons, the Swedes are members of the Teutonic race. The only sizable foreign elements in the population are the 6,000 Lapps and 35,000 Finns. Other aliens total just over 100,000. There has been the same migration trend within the country that has been noted in Canada — a movement from farm to city life.

A waterfall in Lappland

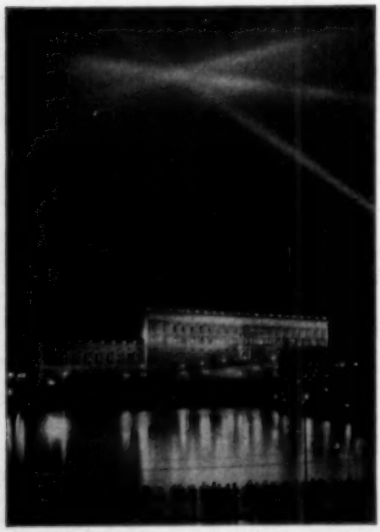
The life expectancy of infants is high — 64.3 years for males, 66.9 years for females. Infant mortality has decreased steadily until Sweden's rate ranks among the lowest in the world — 26 per 1,000 — as against our rate of 45 per 1,000. The tuberculosis death rate in 1946 was 51 per 100,000 which compares very favorably with our Canadian rate of 43 per 100,000.

Kalmar Castle, built in 12th Century

General health conditions in Sweden today are unusually good. The recent legislation governing old-age pensions, replacing the plan first instituted in 1913, ensures every Swede who has reached the age of sixty-seven an adequate pension. The law also provides special pensions for the disabled and blind. In addition, compulsory sickness insurance will be in effect by 1950. This will provide free hospital treatment for an unlimited time, the granting of certain vital medicines free of charge, and other medicines at half-price. Cash benefits will also be available.

The State

Sweden is today a constitutional monarchy governed on a democratic basis under a parliamentary state. While the king is head of the state, he has no political power personally although all government measures are enacted in his name, a form similar to our own. The Swedish parliament, the *Riksdagen*, dates back to 1435. Members are elected through universal suffrage extended to all citizens who have reached the age of twenty-one. The system of proportional representation is used to apportion the seats among the parties. The members of both the first and second chambers are elected, the former for eight years, the latter for four.



The 40th anniversary of the accession to the throne of King Gustav V was festively celebrated. The picture shows the Royal Palace, brilliantly flood-lit, and with a cluster of search-lights from all parts of the city united in a crown of light against the dark skies.

The Church

Sweden was converted to Christianity in the eleventh century. The majority of the people are Lutheran Protestants. Lutheranism is the State religion and, according to the constitution, must be the faith of the king and the members of the cabinet. The only limitation on freedom of worship is that a Swede may leave the State church only if he enters another recognized congregation. The king is the official head of the church but the Minister of Public Worship and Education exercises actual authority.

Culture

The primary goal in Sweden today is to make all phases of Swedish cultural life accessible to the common man. Of particular interest to visitors are the theatre and opera, both of which are largely supported by State money. One feature is the recreational centres with outdoor theatres which provide summer evening entertainment. The Royal Opera runs for ten months of the year.

The Great Out-of-Doors

Outdoor life is a national interest. While the long summer daylight lasts, the roads are crowded with cyclists and hikers. Special train and boat services make the retreat to vacationland easy. Over-night cabins and lodges have been built along most of the country's hiking trails.

The Swedes like competitive sports. Amateur contests predominate — only boxing has a professional standing. The most popular sports are track, skiing, soccer, gymnastics, walking, and a form of cross-country racing where the contestant finds his way by means of compass and map. Cricket, baseball, rugby football, and polo are

not to be found. Golf is still an exclusive game for the few, as is riding. Tennis has an increasing number of enthusiasts.

Travel Guide

Varying natural beauty, cleanliness and comfort, respect for old customs and costumes — these are the main characteristics of Sweden as a tourist country. The Swedes are generally known as a restrained and reserved people. When mingling with foreigners, however, they forget their reticence. Many speak English fluently.

The best travelling time is from May to August, which fits in perfectly with the Congress dates. There are no restrictions on photography so camera-fans may enjoy themselves to the full.

Sweden has left-hand traffic with over-taking on the right so be cautious should you be driving. The speed of private cars is dictated by the demands of traffic safety.

Stockholm

In the twelfth century, it was known as a small fortified island, controlling the passage from the Baltic to the inland lake district. In the thirteenth century, the kings of Sweden moved their headquarters from the old capital at Uppsala to this more strategic spot. While the city has spread to the mainland as well as to adjacent islands, the royal palace and the main administrative buildings are still on the original site, which is called the City-between-the-Bridges. Numerous bridges and water courses criss-cross the busiest parts of Stockholm; ferries and steamboats, as well as trolley-cars, taxis and buses, carry passengers in all directions.

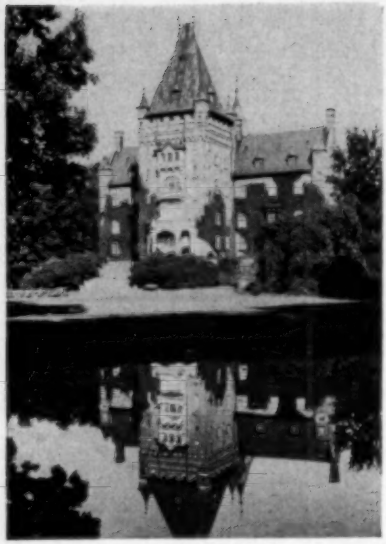
Stockholm City Hall

The wondrous archipelago of Stockholm with its innumerable smaller and larger islands and rocks.

Parks are scattered here and there, and in the summer window-boxes and flower-beds furnish gay spots of color. Trees and water are never out of sight while banks, shops, hotels, restaurants, and theatres are easily reached on foot.

One of the outstanding attractions in Stockholm is the museum, *Skansen*. Here, in an open-air display of old-time life, will be found ancient country buildings, including churches, farm and manor houses. They are completely equipped in the original style. People live and work in the farm-houses. One part of the park is set aside as a wild animal enclosure.

"Kungsgatan" (Kings St.) in centre of Stockholm.



One of the most beautiful manors of Skane is Trollenäs, surrounded by an extensive, beautiful park. Built originally in 1559.

GOTHENBURG

This is the leading city on the west coast and the second largest in the country. It is the headquarters of Sweden's main shipping lines, as well as of its principal fishing fleet. It is also a manufacturing, educational, and art centre.

The Göta Canal was built to connect Gothenburg and Stockholm before the railroads were operated. Via lakes and rivers, through locks and narrow channels, tiny steamboats cross the whole mainland, which is here about 300 miles wide. The trip takes three days.

SKANE

This province forms the southern tip of Sweden. Surrounded on three sides by water, and being fairly level and generally fertile, Skane is not only the granary of Sweden, but it is also its chief garden-spot and is noted for its good food. Many families of the nobility inhabit chateau-like country seats dating from the thirteenth to the seventeenth century.

VISBY

This ancient Hanseatic trading city on the island of Gotland, almost in the middle of the Baltic, retains an air of the Middle Ages. Though some of the fortifications and most of its fifteen ancient churches are in ruins, they remain an impressive spectacle. Our cover picture shows the city wall which was built in the thirteenth century. This wall, with its thirty-seven towers, is still intact. Each summer a colorful miracle play on a medieval theme is performed here.

℞ *Chuckles* P.R.N.

The child may be unco-operative but the nurse may obtain co-operation by using a little tack.

Newly-admitted patients should be treated as if they have a disease until proven that they have not.

An example of a ball-and-socket joint is the eyeball.

The artery supplying the uterus is the ovarian in the female and the spermatic in the male.

A fetus is a grub-like organism which upon delivery becomes a baby.

Labor is nature's way of saying to the mother, "You're finished. I'll take over."

Have the tuberculosis patient speculate into a covered container.

The normal uterus is the size of a silver dollar.

℞ means "Taken inwardly."

Dettol may be ordered for perennial care.

The malar is the sheik bone.

In our efforts to attain better health, we must not only seek to prevent disease — we must make every effort to improve what is now accepted as average health.—THOMAS PARRAN, M.D.

Service for the Child with Defective Hearing

JOAN M. SMITH

IT HAS BEEN estimated that from 6 to 7 per cent of Canadian children suffer from some degree of hearing loss. These handicapped children can be divided into two main categories: the deaf and the hard-of-hearing. Broadly, the term "deaf" means those who are entirely lacking in hearing or whose hearing is too slight to be usable. The "hard-of-hearing" are those whose hearing is defective but still functionable and may be used with the aid of amplifiers or of other artificial means.

NEEDS OF THE CHILD

In planning for the deaf or hard-of-hearing child it must be remembered that he is primarily a child and that his handicap is only one of his characteristics. He has all the normal needs of childhood—the need for affection, for security, of opportunities for new experiences, of approval, of achievement. In dealing with him the greatest harm can be rendered if we treat only his physical disability and forget that because he is deaf he is not immune from other problems.

It is important to view the handicapped child as belonging first of all to a group of children. Nevertheless, it is necessary for certain phases of planning to think of him as belonging to the group of people with an auditory handicap and to recognize the special implications of the defect in order to work successfully with him. With respect to individual educational, recreational, and vocational planning it would seem to be justifiable to consider the deaf child as a deaf individual as well as to consider him as a child.

PROBLEMS OF THE DEAF CHILD

The most serious problems of the child who is born deaf or who becomes deaf before speech and natural language was established, arise, not from his physical inability to hear, but from the impediment in social development which results from the inability to use and understand speech. Language is one of the most important means of socializing the child. The deaf child, however, is deprived of this avenue of communication; he has to depend upon his eyes for the acquisition of a somewhat vague understanding of the behavior of those about him. His mind has not received the stimulation of the sound of speech and in consequence the early education in living, which hearing children acquire within the family group, is barred to him. It is obvious that if the child is to compete later in life with his contemporaries, compensation must be made for this deficiency in the form of special education. It is the present belief that the deaf child should be taught speech at approximately the same age as that at which he would normally acquire it, that is between the ages of two and five, when he has the psychological urge to speak.

Because the normal avenues of obtaining knowledge are closed to him, the education of the deaf child is much more slow and painful than is that of the hearing child. It is believed that the deaf child should have not less than twelve years and preferably not less than fifteen years at school. The education of the deaf child is usually carried out in an institution in which both academic and vocational instruction is given. There are six of these institutions in Canada.

The handicap of deafness provides problems not only in the mental but also in the emotional development of the child. The physically defective child tends to pattern himself upon the stereotype of his group as pictured by society. Thus his physical imperfection becomes an actual disability only when he senses that it is a

Miss Smith is a graduate of the McGill School of Social Work and district assistant in the Verdun (Que.) Family Welfare Association.

defect and becomes aware of a consciousness of his handicap in the people among whom he lives. Because of the ignorance of his family and acquaintances concerning his potentialities and their subsequent attitude of condolence towards him, the deaf child may develop personality problems which are a real handicap. He may learn to anticipate pity and become submissive because of his constant awareness of his physical defect.

Because of the social cleavage between deaf children and hearing youth, the former require help in their social adjustment. An important role in this process can be played by the establishment of organizations composed solely of the deaf, in which they have an opportunity to communicate with their fellows in a common language. In a junior group of this kind the deaf child will not experience a feeling of being "left out" which may occur in groups of hearing children where he is unable to follow the conversation or fully participate in the activities. This does not imply, however, that deaf children should be isolated; it is desirable that part of their play should take place in groups of hearing children to facilitate their later adjustment into a hearing world. At the same time it is necessary that part of their recreation should be devoid of the necessity of tense concentration; this is accomplished among other children who have the same limited means of communication.

Problems of the Hard-of-hearing Child

The hard-of-hearing child suffers from a handicap less severe than that of the deaf child, since he established speech and the ability to understand language and subsequently developed an impairment of hearing. The hard-of-hearing child is sound-conscious and has an almost normal attitude towards the world of sound in which he lives. Consequently his needs, although similar, vary slightly from those of the deaf child.

The educational service to the hard-of-hearing child consists chiefly of conservation of the language, which has already been acquired, by means of speech correction, the teaching of lip-reading, and the re-education and utilization of residual hearing with the help of hearing-aids. It is often possible for a certain number of these children, after they have received full benefit from the above-named services, to resume ordinary classes in the public schools.

The psychological difficulties of the hard-of-hearing child tend to differ from those of the deaf child. The impairment of hearing which occurs during school years may pass unnoticed. The child may then fall behind in his school work and develop feelings of inferiority which result in grave personality problems. Once his hearing handicap has been discovered he may find the psychological adjustment to the hearing-aid difficult and, hence, require help in understanding and accepting the need for the aid and his own feelings concerning it.

Medical Aspects of Hearing Defects

Auditory defects can be divided, from the etiological point of view, into two main categories: congenital and adventitious. The former group comprises more than one-third of the total deafness. Since medical knowledge concerning the causes and prevention of congenital deafness is scant and incomplete, the range of medical services to this group is not large.

Adventitious hearing defects are, above all, a medical problem, since a very large proportion of deafness occurring after birth is of a preventable nature. Many children acquire hearing defects as a result of infantile and infectious diseases. An important part, therefore, of the medical service with respect to deafness should be preventive and should be directed against meningitis, scarlet fever, diphtheria, measles, and other diseases which may affect the auditory acuity of the child. A second phase of the medical prevention of deafness involves increased attention to the conditions of infancy which might lead to progressive deafness; acute sup-

purations, hypertrophied tonsils, diseased adenoids, inflamed nose and throat regions.

Thus the efficiency of the general public health program, especially with respect to inoculation and isolation, and the adequacy of child and infant clinics and health services, plays an important role in the prevention of defective hearing.

Hospital Service

Hospital service with respect to an auditory handicap consists of three phases: diagnosis, treatment, and rehabilitation. The diagnosis may begin in the pediatric clinic where, during a general physical examination, it may be detected that the child has imperfect hearing. He is then referred to an otological clinic for more detailed diagnosis and treatment. Many of the referrals of children to ear clinic come also from private physicians, schools, or the family of the young patient. Rehabilitation may begin in the otological clinic, with adjustment to a hearing-aid, and continue in the speech clinic, where the child learns to use his newly-found or regained hearing in producing correct speech.

Since the otolaryngology clinic is the chief source of medical care for the deaf or hard-of-hearing child, some evaluation of his opportunity for treatment and rehabilitation may be made by means of a brief survey of these clinics within the hospitals. From the accompanying table it will be seen that the province of Quebec, in which resides approximately 29 per cent of the population of the

Distribution of Otolaryngology Clinics Throughout Canada in Comparison with Clinics Serving Other Physically Handicapped Groups (1)

Province	*Population Per Cent*	*HOSPITAL CLINICS*					
		Otolaryngology		*Orthopedic*		*Ophthalmology*	
		No.	*Per Cent*	*No.*	*Per Cent*	*No.*	*Per Cent*
Canada	100.00	99	100.00	79	100.00	92	100.00
P.E.I.	.83	1	1.01	1	1.27	1	1.09
N.S.	5.02	3	3.03	3	3.80	4	4.35
N.B.	3.97	5	5.05	4	5.06	5	5.43
Que.	28.96	40	40.40	23	29.11	35	38.04
Ont.	32.92	34	34.34	31	39.24	31	33.70
Man.	6.34	7	7.07	6	7.60	7	7.61
Alta.	6.92	—	—	1	1.27	—	—
Sask.	7.79	4	4.04	4	5.06	4	4.35
B.C.	7.11	5	5.05	6	7.60	5	5.43

(1) Data from the Canada Year Book (1943-44), pp. 79 and 965. Some changes in the number and distribution of clinics may have occurred since that time.

Dominion, possesses more than 40 per cent of the otolaryngology services in Canada. Since, however, these clinics are found in the cities, chiefly Montreal and the city of Quebec, they cannot be considered accessible to a large proportion of the rural population. Such availability could be achieved if some adequate system of discovery and follow-up of children with hearing defects were in operation throughout the province.

In view of the fact that the deaf and hard-of-hearing are believed to be in many respects the most neglected group among the physically handicapped, it is of some interest to compare the medical services for them with those available to other handicapped groups. As can be seen from the table, for Canada as a whole there are more clinics serving the auditory than the orthopedically or ophthalmically handicapped. Only two provinces, Alberta and British Columbia, have more orthopedic than otolaryngolical clinics—in each case one more—and only one province, Nova Scotia, has one more ophthalmic than otolaryngolical clinic. In making these comparisons it must be remembered, firstly, that there is no indication from the figures quoted above, either of the number of specialists within the clinics, nor the number of patients; secondly, the otolaryngolical clinic gives treatment to a large variety of diseases and conditions. Nevertheless, it can be concluded that, from the point of view of medical service, the child suffering from an ear condition is not less adequately served than any other group of physically-handicapped children.

Public Health Nursing Service

Frequently, it becomes the responsibility of the public health nurse to make available different resources to the child and to aid him in his adjustment to his handicap. Once the child has been steered through the appropriate clinics, she may undertake planning for his rehabilitation by carrying out recommendations made by the doctor, such as referral to speech clinic, and by assisting the parents to make application to the appropriate educational resource. Further interpretation of the child's difficulties and some education in the family treatment of them may be given to the parents. If there are basic family or personal problems which will affect the child's adjustment, she becomes responsible for assisting the parents in gaining an understanding of the implications to the child of his handicap, and of their own attitudes towards him and his physical defect. The aim of her work with the family is to help the members to recognize the importance of treating the handicapped child as far as possible as a "normal" individual by avoiding over-protection. Service to the child consists of helping him to adjust physically and psychologically to his handicap in order that he may make the best possible adjustment in the hearing world.

Goals of Work

The underlying principle of any work with the child with a hearing defect is to plan with and around his handicap (not in spite of it) in order that he may develop the ability to lead a satisfying life and to use all his available capacities. To achieve this goal, co-operation is needed among all those who come into contact with the child and have responsibility for some area of his well-being—doctors, nurses, teachers, and social workers, as well as his family. To give adequate service to all deaf and hard-of-hearing children, it is felt that a co-ordinated program is required, containing the following features:

1. The location of all children with an auditory handicap.
2. The provision of skilled diagnostic and medical services, available to all.
3. Provision for the education and vocational training of these children.
4. Co-operation with professional groups and private organizations in providing services for deaf and hard-of-hearing children.
5. Co-operation between health and welfare groups in the treatment of unfavorable social conditions that affect the child's emotional and social adjustment.

Night Watch

B. Banfill

With Newfoundland and Labrador so much in the news these days, we should know something about these hardy fisherfolk who are soon to be our fellow Canadians. Many people do not know that there are two Labradors. The other is in the province of Quebec, extending approximately from Havre St. Pierre to the entrance of the Strait of Belle Isle. Most of the fisherfolk here originally descended from Newfoundlanders. It is about Canadian Labrador I am writing today.

A man is taken sick. His wife picks up a telephone. In half an hour the doctor is examining him. In another half-hour an ambulance is at the door and in fifteen minutes the sick man is tucked in a hospital bed, surrounded by blankets, hot water bottles, nurses, and luxury. Yet many of these same patients continuously grouch because their bath is fifteen minutes later than they want it; because a bounteously laden tray did not arrive just on time; because their bell was not instantly answered. This, of course, was in the city — not on the Labrador Coast.

An emergency call had come along the Coast. It was the first week of November. On Thursday evening the doctor received a call from over a hundred miles away, from an isolated harbor. It was impossible for him to leave so he wired to me, thirty miles away, asking if I were free to answer it. After two unsuccessful hours attempting, in three villages, to obtain a cabin boat, I had to wire the doctor, "No cabin boat available." Winter was upon us, so all cabin boats had been hauled up. The round trip would mean approximately 225 miles, with several nights aboard a boat. It was not the distance but the sea and weather we had to contend with. No man would dare risk such a trip in an open boat, because, should he get caught in a storm, we would certainly freeze to death.

At eleven o'clock that night the doctor wired, "Cabin boat located. Boatman willing to attempt trip at daylight tomorrow. Will call for you." The next morning a wire came saying, "Terrific sea at Harrington makes travel impossible today." Saturday forenoon the boat docked at our Mission and I went aboard. The day was with us and our boat sailed along like a swan.

At this time of the year it is not safe to travel after dark so at five o'clock we ran into a cove and dropped anchor for the night. A new experience confronted me. To pass the night in one cabin approximately six by ten, in which there was a stove, table, two berths, a swinging lamp, two men and me, plus our extra clothing, wood, food, and supplies, but with absolutely no privacy! Knowing that this was my first long-distance, close-quarters, non-privacy, minus-necessities trip, the boatman casually said, "My son and I will go out on deck while you get ready for bed." I crawled under and among blankets, turned my face to the wall, and shouted "All right." The two men climbed into the other narrow bunk.

Five-thirty came and the men crawled out. Mr. James said, "You do not need to get up yet." At seven o'clock he stuck his head through the door and said, "Better crawl out before we get into loppy water." We started and plowed our way through icy green water and biting chill air. Just as we cast anchor in the harbor of our destination, a blinding blizzard struck and it snowed all night.

This was Sunday afternoon. The patient had been suffering with retention of urine since the previous Tuesday and his agonized groans could be heard all over the home. He would never live to reach a doctor or hospital without at least a day's treatment. I gave him a hypodermic and wired the doctor: "For various reasons impossible to catheterize; patient de-

lirious." "Do a paracentesis," came the reply.

I had never done nor seen this treatment administered, but if it were the only thing to do I must do it. I set to work.

In a hospital, when a doctor is going to do a paracentesis, the nurse calls the operating-room and in a few seconds a sterile tray with all the necessary equipment is set before him. Not so here! I emptied out the contents of my nursing bag. Fortunately, I had a large needle and a small rubber tube. I connected the two, sterilized them and, with the free end of the tube in a bottle on the floor, almost shut my eyes and made the puncture.

When I had withdrawn ninety ounces of urine, I recalled a lecture when a doctor said there is danger of collapse if too much is released at one time. I clamped off the tube. In three hours the patient was rational and much more comfortable. During the night and the following day and night at intervals I released the clamp.

Monday night the weather turned much colder and the boatman came in. He said, "If you wish to get out this fall, we will have to leave at daybreak. If not, my boat will freeze solid."

The husband-father could not live long at home. He might die at any moment along the journey, or he might not come through an operation. Coast mothers and wives have to face many stern realities with fortitude and calmness. I could not remain away from my station and the mother could not leave her children, the telegraph and post office, to accompany her husband. He would have to set off on this uncertain trip with me in attendance, whom he had never seen before. They knew the uncertainty of boat travel at this time of the year. My only comfort was that God was with us on land and sea and we would have to place ourselves absolutely in His merciful hands. After prayers and consultation, the family and patient felt that we should try to get him through to a doctor and medical attention.

Tuesday morning, we carried the patient downstairs and placed him on the hand-made stretcher, which men carried to the water's edge and placed across the canoe. We cut our way through shimmering ice to the boat. It was a perfect day.

At four o'clock, the boatman remarked, "What an ideal day!" and the patient replied, "God has been with us to give us this day."

At four-thirty, like a thunderbolt from the blue, a blizzard came swooping down on us. The force of the gale swung the boat about and a wild sea faced us. The boat quickly became coated with ice and snow. In a tense voice Mr. James shouted to his son, "Nothing to do but find some sort of shelter and that quickly. The anchors will not hold here." Hastily Tom lashed everything to the deck. The cabin lamp swung from side to side like a hammock. The boat pitched forward, lurched backward, and then rolled broadside. It seemed to do all three at the same time. Outside all was blackness. The sound of the breakers grew louder and closer, as they broke booming with fury against the rocks.

It was a ghastly business to have the responsibility of this unquestionably dying patient, enveloped in blackness, anchored on a rolling, mad sea, in a blinding blizzard, and not know when and how we would be able to travel forward.

Here we were, and here we stayed until two o'clock the next afternoon. An emergency patient being rushed to a doctor; death facing him; every moment counting; not a relative aboard; no means of communication with land, and frequent treatments requiring a sterile needle and syringe! A swaying wood stove and a sliding basin in which to boil my sterile equipment did not help matters.

The patient accepted his fate without complaints against the weather or the sea. His was an inner calm, practically unknown to the average city person, as he lay there and awaited his fate. His calm patience inspired me with confidence and strength and spurred me to do my best.

Bedtime came. Inside the one cabin was a bed patient and two other men, while outside was an icy, slippery deck. Balancing on that treacherous deck, under the inky black sky, showered with snow and spray, braced against the terrific force of the wind, I prepared for bed, while the men spread a deerskin and blankets on the floor of the cabin for me.

At two o'clock the next afternoon Mr. James exclaimed, "She has stopped!" The men unlashed the equipment, started the engine and we were on our way. The sudden calm made me think of "Peace be still." Were our prayers answered in time?

At dark we reached a harbor. The men went ashore to sleep. Before going ashore, Mr. James left me wood for the stove and drinking water. Also, he said, "Here is the police whistle. If you feel the anchors giving away or the boat drifting out to sea, blow three blasts and I will row out to you."

Tired as Mr. James was, probably it would have taken a bomb to waken him once he had a chance to sleep in a non-swaying bed. However, with him asleep ashore and with the police whistle dangling about my neck I felt perfectly safe, but not sleepy, and thanked God for a dark deck. In the stillness of the eerie watch, while the boat heaved and tugged at the anchors, and the anchor lines kept bumping the sides of the boat, the patient whispered, "Is that Gabriel thumping on the wall? Has he come for me?"

Daylight came, bringing with it an ideal day. After six hours, with sails full spread, we arrived at the Mission wharf where the doctor greeted us. Just one week from the day the emergency call had reached the doctor, we were able to turn the patient over to him. A great load of responsibility rolled from my shoulders.

The next afternoon, before I left for home, I went to say goodbye to the patient. He was just finishing a letter to his wife, so that he could send it back by the mailman with whom I would travel home.

The need, the challenge, and the fascination make life full and satisfying for nurses and doctors. Just at present, hundreds, perhaps thousands in Canadian Labrador have no doctor or nurse to whom they may turn in distress.

The harvest truly is great but the laborers are few!

Five Years After

NORAH L. CORNWALL

As an ex-naval nursing sister, I found myself in 1944 a civilian with salt in my veins. It was a strange feeling to have had a Medical Board and to have been found wanting, in the midst of a war, especially with an overseas draft in the offing of which we had all been living in hopes. Naval nurses were not as fortunate as army. We had only one overseas base — *H.M.C.S. Niobe*, Scotland. Everyone couldn't be given a draft there, much as we pleaded.

However, to get back to me — I loved the navy and still do. It was a good life, really. You had a band to make beds by, a deck to walk on, a "ship" to work in. When you entered barracks you came "aboard"— when you left you went "ashore." When you were tired you "flaked out on your mick." Almost everyone saluted you and you saluted almost everyone else. (A sub-lieutenant is practically the lowest form of officer-life.) Yes, I'll always love the navy. Of course, all my ancestral forebears had followed the sea, so perhaps that accounts for it.

A medical discharge is at least an honorable discharge, which was little consolation in 1944. However, one must face these disappointments like a soldier even if one were a sailor. Oh! yes. I'd had a few illnesses — who hasn't! Measles, mumps, whooping cough, and chickenpox as a child (my grandmother didn't think you could live to be an adult un-

Miss Cornwall is engaged in industrial nursing with the Department of National Defence Naval Service at Victoria, B.C.

less you had had all of these). Later on a cervical adenitis; my share of colds; then "flying fatigue" developed while employed as stewardess with T.C.A. A "nervous breakdown" my friends used to whisper for months afterwards. "An N.B. you know!" "No," I would hear them say, "not really — isn't that positively dreadful!" (accenting the "dread"). "Oh, I don't believe you" (sideways glances would follow this to get a glimpse of the specimen who was actually there in their midst). I began to feel as if I had had the black plague or was one of the untouchables of the Far East. When I look back on that part of my life it was really quite amusing.

Oh yes, I almost forgot. I caught a beautiful dose of infectious mononucleosis while serving in the naval hospital. This was my undoing. This is a comparatively rare condition somewhat resembling undulant fever. Three weeks' hospitalization followed, with a daily temperature range of from 94° to 105°. While this was going on, one felt quite a bond of affection for the dish-rag — a matter of kinship, I suppose. It seemed no one knew very much about this disease in 1943. So I tried to be a good guinea-pig and answer the innumerable queries of dozens (or so it seemed) of M.O.'s.

Following a fortnight's convalescent leave, I reported back to barracks only to be met with a summons to the matron's office. This was it! My draft had come at last! My spirits soared. It was a draft all right — but of a different sort. The Medical Board and subsequent discharge were the results.

A Board is a humbling experience. Everywhere one looks there are M.O.'s. Tall, short, thin, fat, bald and bored, all sitting around in a circle on stiff-backed chairs — all looking at you. My sense of humor stayed with me, thank goodness, through this episode. Tears weren't very far from the surface at times but managed to remain submerged by an act of the will. Looking at all the funny medical officers was really worth the ordeal, I decided.

Outside, in the good clear fresh air afterwards, I paused to think. This I never should have done — for "he who hesitates is lost." What did it all mean? That I was finished — washed-up — "had had it," as they say? I had always understood that the average life expectancy was threescore years and ten, and I had only lived a few years longer than one score. Surely this did not mean that I was going to "pack-up" as early as all that. Meditating thusly, the matron's form appeared from nowhere. She took my arm and rushed me here and there. Gas mask must be turned in — dental clinic must be visited. "Three cavities," I heard someone say. "I'll have them filled by my own dentist," I heard myself say. "No, no, you must have them filled now, before you leave," replied the dentist. Yes, you guessed it, I did. After this "ten more establishments to visit before noon," the matron said. It was already eleven o'clock (or 1100 hours nautical time). Away we flew. Up and down stairs; in and out of doors, past commodores and guards, ratings and admirals. Why it all had to be accomplished so quickly, I didn't know. Perhaps I had something else and they were afraid it would break out before noon. Yes, that must be it! At last we were in front of the Discharge Officer. I was quite out of breath by this time and probably looked a little dazed. Surely someone was sorry to see me go. Here was a man who was supposed to do nothing but discharge people. Surely he'd be sorry. I put out my hand thinking he might like to wish me Godspeed. I was mistaken. He didn't. Instead he thrust another document into my hand and grunted. Something else official no doubt, I decided, and thrust it into my already crammed hand-bag, to be looked at a little later when I felt a little stronger. I smiled weakly and left as gracefully as I could.

Outside once again, the sun was shining at least. Beautiful, warm sun, how I loved you then! Your rays seemed to express a warmth no handshake could. The air was balmy. I breathed deeply and thanked God for the sun. There were other things one could do, I knew. I was still an R.N. and I loved nursing and always would. But passing through the barracks gates a few tears began to trickle. Perhaps it was hunger or tiredness or disappointment or all three. Later on at home that same afternoon I decided it was because I was really sorry to leave the navy. If it is ever necessary to enlist again to defend our way of life I shall be one of the first to appear before the recruiting officer, and shall try to convince him that a staunch and willing heart is just as important a qualification of a naval officer as a category "A" medical.

Just enough conceit and just enough vanity will help create, but when flaunted, they destroy the creator.

Public Health Nursing

What do Student Nurses Learn about Public Health?

ALICE G. NICOLLE

A COMMITTEE was appointed by the Registered Nurses' Association of Ontario to study the role and status of the public health nurse in a school of nursing and to inquire into the methods of integrating health in the basic curriculum. A summary of their findings is presented herewith for the general information and interest of the nurses of Canada.

The following objectives were set up by the committee to guide them in the study:

1. To evaluate the degree to which the promotion of health and social awareness is already integrated in the curriculum and the life (total living conditions) of both students and staff in schools of nursing.
2. To study the need for health instruction, health supervision, and health practice in schools of nursing.
3. To survey the opportunities already available in the hospitals and schools of nursing which can be used to contribute to both health knowledge and practice of students, staff, and patients.
4. To study the status and function of a public health nurse in a school of nursing, and the preparation needed to discharge her duties successfully in the interest of students, staff, and patients.

The members of the committee were representative of the various groups in nursing interested in the education of the undergraduate student in schools of nursing and in the field of public health, together with the employment of nurses in both fields.

They brought to the study the pertinent factors in administration, supervision, instruction, and clinical teaching in hospital and public health nursing. They provided a variety of viewpoints invaluable in arriving at an understanding of the present situation in schools of nursing and public health agencies which have to be considered in relation to the study of public health integration.

Several meetings were devoted to the study of trends in this phase of nursing education and their implications. Some of the lines of thought were:

1. The increasing requests from schools of nursing for student observation with public health nursing agencies and the probable reason for these requests.
2. Increasing requests from local public health agencies and individual public health nurses for help in planning observation, particularly in regard to length and content of this experience, and for outlines of lectures which the public health nurse could give to undergraduate groups at the request of the local hospital superintendent of nurses.
3. Requests from public health nurses employed in schools of nursing for assistance in planning or re-organizing their programs.
4. The questionable value to the student of a period of observation with a public health nurse or local organization, when her education in the school of nursing had included very little of health knowledge and, therefore, of social awareness, which would help her to benefit from observation in the

Miss Nicolle, who served as convener of the special committee that made this study, is educational supervisor with the Division of Nursing of the Ontario Department of Health.

community. This was compared with the possibilities of learning and practising health throughout the whole of the three years of the undergraduate course, with a short well-planned period of observation in the community, not as an isolated piece of experience, but as a part of integration, a broadening-out of the process started in the school of nursing itself and on the hospital wards.

5. What of present community observation — was it an educational procedure? What was the student's previous preparation for this experience? What factors might have to be considered by the public health agency offering such experience if the results were to have the intended value for the student?

Where qualified public health nurses were employed on the school of nursing staff it was agreed that a better integration should be possible. It seemed appropriate to analyze her functions in some detail. Furthermore, though all staff members share in the opportunity to guide the young student, the question was raised of the qualifications needed by the person who would lead in the guidance program. The role of the public health nurse on the staff of the school was studied in relation to:

1. The *educational needs* of the student and the needs of the graduate nurse as citizens in the community as well as professional people.

2. The *nursing needs* as well as the educational needs of the patient.

3. The *use of the pre-test* in evaluating the health knowledge of all students entering schools of nursing, for many high schools still provide only a minimum of health teaching and often no health service through which young people learn to practise health; in other high schools students receive a good deal of health instruction. With the use of a pre-test, the level of health knowledge in a group of entering students could be evaluated and the results used as a basis for teaching.

4. The *necessity of preparation for the staff* if integration is to become the responsibility of all those who are concerned with the care of the patient and the education of the student.

5. The *scope of integration:* How does the integration of health knowledge take place? Should it not include practice of healthful living as well as classroom teaching? What practice in the student's daily experience has health significance? Only through personal experience does it seem possible: (a) to help young students to understand the importance of the preventive and social aspects of a community program; (b) to understand what a patient's hospital experience means to him in relation to his previous life experience and his future.

6. The *health needs* of the undergraduate students in relation to their youth and inexperience when they enter a school of nursing and the hazards to which they are exposed: (a) a highly concentrated and technical course of study given within the first six months; (b) an entirely new environment with a large group of sick people; (c) fatigue — often extreme; (d) pressures of work, on the ward and in the classroom; (e) adjustment to many personalities.

7. The *need for a guidance program* based on approved techniques, in order that the student may be guided during the whole three years to become an understanding and independent person since this is the role we hope she will take in the guidance of her patients and perhaps their families. Poor guidance techniques, on the other hand, might well contribute to student dependence and undue introspection.

At this point we were ready to consider the method by which existing schools of nursing in the province could be brought into the study for we needed their interest and the contribution we knew they could make. Our method of doing this was to formulate a questionnaire which roughly outlined the various avenues through which health and social factors (or social awareness) might be integrated. The questionnaire was sent in duplicate to all schools of nursing in Ontario. These included 59 hospital and 2 university schools of nursing. Forty completed questionnaires were returned, as well as one report incomplete due to the fact that the school was closing. Of these, 14 schools employed public health nurses. At the time that this questionnaire was distributed there were 4,241 students in training in Ontario. Of these, 3,757 were in the 40 schools of nursing reporting in this study.

Space does not permit the publication here of all of the material which was tabulated. Some of the more important data are presented, together with the conclusions and recommendations made by the committee.

Health Service

All schools reported a health examination as a requirement for entering students. When the examination is provided after the student enters the school, an opportunity is afforded for a member of the school of nursing to prepare them, explain the examination, and plan a follow-up conference with each. These early contacts provide a means of discovering their need of health knowledge and practice. This information can then be used in planning for the course in personal health and, when necessary, for personal guidance.

If health teaching to students is to begin when the student enters, the procedures included in the health examination should be used as a basis for the course in personal health. They should serve as a demonstration of good health practice, and as a means of securing the students' understanding of the relationship between the scientific information acquired through lecture and study, and the preventive aspects of the procedures experienced while being examined.

Using the Health Service Information

In answer to the question, "What use is made of health service procedure and findings in teaching the student nurses?", 18 replies were received from the 26 schools without a public health nurse on the staff. The following are some of the best answers:

Immunity is taught when the nurse is receiving inoculations.

Correlation of preparation of student on admission with admission of patient to hospital. Used in teaching personal hygiene, bacteriology, anatomy, physiology, and psychology.

Early in preliminary term, health service tests and reactions are explained to class.

Instructors are encouraged to correlate theory, including instruction on public health matters, to the actual practice of the student in regard to her personal health practices and to that of her patients.

During the course in health education, the model health routine for schools of nursing is discussed with the student.

From the 14 schools with a public health nurse on the staff, 13 replies were received. The following answers indicate a somewhat different approach:

Before initial physical examination or test, a full explanation is given; defects are explained individually.

In health service procedure the students have a practical demonstration of the value of periodic medical examination, the importance of good health habits and early correction of defects. This personal experience also serves to make student's health teaching on the wards more convincing.

The student's personal "health inventory" becomes the basis for her individual health course. Preventive measures are also put into practice whenever possible.

An effort is made to make the student nurses realize that the hospital is a health centre in the community. Just as hospital authorities work to have their students x-rayed and immunized, so also the student nurses would bring to bear upon their patients the value of annual physical examinations, x-rays, etc.

The prevention and control of communicable diseases, if made applicable to themselves, and the value of regular physical examinations in preventing illness are stressed; their responsibilities and opportunities for teaching healthful living are pointed out, good personal and community hygiene emphasized.

The Cumulative Health Record

The cumulative health record is a record which includes:

1. The student's previous health history.
2. The student's own estimate of her personal health and health habits.
3. The findings of the entrance and subsequent medical examinations; illness or accident occurring during the course.
4. The results of general health guidance—

e.g., her increasing ability to take responsibility for her own health adjustment and needs, or for seeking guidance when necessary.

It is understood that under certain circumstances this health record alone would not be sufficient but that it would be used in relation to other records, usually filed in the office of the superintendent of nurses.

Student Observations

From the diversity of plans for student observation in the community it is apparent that schools of nursing are interested in and have sought this experience on whatever basis was obtainable in their locality; and that a more equitable distribution of available facilities for observation might provide a short period for every student. A quarter of the schools provided this experience in the third year only; the same proportion gave it all in the second year. Superintendents of nursing were asked if they thought that community experience would contribute to the care of the patient: 23 answered — yes; 6 — possibly; 4 answered — no; 7 did not reply.

Answering the question, "What use is made of the student's community experience in the nursing

TABLE I

Community Observation for Students

Period of Observation		*Students Receiving Observation*	*Schools*	
V.N.A.	*Dept. of Health*		*With P.H.N.*	*No P.H.N.*
Maternity only	..	Some	..	1
1 month	½ day for 3 wks.	all	..	1
2 days	1 visit	all	..	1
..	4 days	all	..	1
..	1 month	not stated	..	1
2 days	..	all	#2	3
1 day	..	all	..	1
½ day	1 visit tb. and child health cl.	all	..	1
1 week	2 weeks	all	..	1
..	1 week	all	..	4
..	1 day	all	..	1
..	2 days	all	2	1
2½ days	½ day	(a)	2	..
1-4 days		Optional	2	..
1-4 days		all	1	..
½ day	½ day	66%	1	..
3 days		66% (b)	1	..
3½ days		75% (c)	1	..
2 days	1 week	all	1	..
3 months' supervised practice		all	1	..
No observation period		..	..	8
No reply given		..	..	1
Total			14	26

One is a university school.
(a) Those interested or with highest standing.
(b) Availability deciding factor.
(c) Interest and suitability are deciding factors.

care given to patients in the hospital?" 15 replies were received from the 26 schools without a public health nurse. The following are some of the best answers:

Improves social welfare attitude and community service.

Added emphasis on health teaching.

Nurses have knowledge of the community needs, agencies, health teaching, and school nursing.

Insight into patient's living conditions.

I don't think we have given this much attention in the past, but I can see that it would be of value to the student if she was required to make definite application of knowledge acquired.

Able to advise patients of community resources, clinics, and health services available.

Student made to realize the patient as an individual and a part of community life where he resides.

Of the 14 schools with a public health nurse, 13 replies were received. The following are some of the best answers:

The student is given a picture of the health teaching in the community. There should be a means of doing supervised health teaching on the ward.

Students are encouraged to take a more personal interest in the health and care of each patient and put into practice on the wards health teaching learned in the district.

No definite use but tends to broaden student's understanding of patient, particularly in the case of ward patients.

Each nurse visited a patient who had been in hospital and this gave her an insight into home conditions which helped in dealing with other patients.

The nurse is expected, on finishing her experience, to have a working idea of community resources. Advise the mother of the value of having the public health nurse visit herself and her baby; be able to explain the work of the visiting nurse and her duties apart from the public health nurse.

Formal Health Instruction

"In which courses are students receiving instructions in preventive as well as curative measures?" All but 2 of the 40 schools replied to this question. Some of the best answers were:

In preliminary course on health in discussion on health service.

Personal hygiene in preliminary term. Health education related to the family in the second term, community health in the third year.

Health education, including mental hygiene, study of community health, and prevention is integrated throughout the study of the entire course of training as much as possible.

Endeavor to stress health whenever possible from the beginning of the course.

The whole curriculum of the school is built around teaching students prevention as well as curative measures.

Throughout the three years' training in all lectures and courses given — also in clinical teaching given on the wards. Emphasis is placed on preventive measures.

An honest attempt is being made to integrate this teaching in every course, such as nursing theory and practice, anatomy, medical and surgical, communicable diseases, pediatrics, etc. A course in health education and preventive medicine is also given.

This is given emphasis in all teaching notably in the subject of nursing. Comprehensive instruction is also given concerning the field of public health and public health nursing.

Some Conclusions

Hospitals and schools of nursing present many more opportunities for learning and practising health and preventive measures than had been previously thought of or that are being used at the present time.

The hospital wards as well as the out-patient departments provide unlimited material for the development of a social awareness on the part of both student and hospital staff.

The use of some opportunities in the education of the student, the continuous education of the staff and through them the care and rehabilitation of the patient, require that all staff members be prepared to assist with the integration of health and social factors throughout the school and hospital situations.

TABLE II

TRAINING, EXPERIENCE, STATUS, AND SOME RESPONSIBILITIES OF PUBLIC HEALTH NURSES IN 14 SCHOOLS OF NURSING IN ONTARIO

	Detail	*No. of Schools*
Professional Preparation	Certificate in public health nursing & B.A.	5
	Certificate in public health nursing only	8
	"Short course in P.H.N."	1
Post-graduate Experience	None	7
	Under 1½ years	2
	Over 3 years	3
	Over 5 years	2
Relation to Health Services	Health service to student nurses	9
	Seven of these reported the following:	
	Nursing care of sick students and staff 3	
	Some attention to employees 2	
	Student accidents and first aid to staff 1	
	Night calls to sick nurses (in part) 1	
	Registered nurse in charge of health service	4
	No reply given	1
Responsibility for Health Guidance	Health guidance to all students	6
	All guidance of students	1
	Shared responsibility with all staff members	3
	Participation on guidance committee	1
	Not responsible — director of nursing responsible	2
	No reply given	1
Responsibility for Classroom Teaching	Of the 14 public health nurses concerned, 12 are reported as teaching in the classroom from 18 to 80 hours during the school year (an average of 33 hours per nurse).	12
	Number of hours not given (considered an integral part of the whole program)	1
	Not responsible for classroom teaching	1
Subject Taught in Classroom	Personal hygiene	11
	Community health	12
	Social aspects of nursing	1
	Public health nursing	2
	Health education	1
	Preventive medicine	1
	Mental hygiene	1
	Venereal disease prevention	1
	The normal child	1
	Demonstration of home nursing procedures	1
Part Taken in Staff Education Program by P.H.N.	An active part	7
	No organized program	5
	No reply given	2
Other Duties for which Public Health Nurse is Responsible	Assisting in organizing out-patient department clinics	1
	Part-time cancer clinics	1
	Part-time librarian	1
	Assists or is responsible for planning field trips and affiliation	8
	Follow-up and conferences after trips	6
	Relieving in the school of nursing office	9

The increasing number of schools interested in finding opportunities for their students for observation with public health agencies in the community makes it necessary for these agencies to reduce considerably the

period given to each student. It follows that opportunities within the hospital, used to good advantage, would prepare the student to make the best use of this short period in the community, not as a means of interesting the student in the public health field, but in developing her social sense and responsibility as a citizen.

The observation period in the community itself needs careful planning, with clearly defined objectives for both the hospital and the public health agency giving the experience.

The public health nurse on the staff of the school of nursing in the present program spends a large percentage of her time in working directly with the student.

Because of the variety of duties at present undertaken by the public health nurse, and the changes which may be expected to take place as other hospital personnel become prepared to assist with the integration in courses and activities, her role in the school of nursing has not yet been entirely clarified. It is clear, however, that although her duties include some supervision and instruction of students, she does not fit into either of these categories.

Some Recommendations

1. That an effort be made to gradually relieve the public health nurse of all duties which could be undertaken just as efficiently by any graduate nurse in order that the public health nurse may use more of her time: (a) To assist with the integration of the health and social aspects of nursing wherever she sees the opportunity in the school of nursing or hospital situation; (b) to act in the capacity of adviser to the supervisory staff who are often better able to assist the student and patient on the wards and in the out-patient department.

2. That consideration be given to the type of preparation needed by the public health nurse in order that she may be adequately equipped to assist in the development of an integrated program in the school of nursing.

3. That practical and economical means be found to assist hospital personnel to prepare themselves to plan for and carry out this integration.

4. That the opportunities within the hospital and school of nursing for (a) the integration of health, preventive, and social aspects of nursing in the basic education of the graduate student, and (b) the scope of the public health nurse in this program be carefully explored through panel discussions, articles, and in discussion groups, such as refresher courses or workshops.

5. Where a public health nurse is not employed, as in many smaller schools, it is suggested that one or more members of the local public health agencies offer consultation service to assist the study group.

Malnutrition

Some types of malnutrition are strikingly obvious to everyone, some are apparent only to the physician who looks for them, and some are vague and elusive even to the careful observer using the most accurate specialized techniques. If the first group alone is counted the prevalence will be recorded as low, almost negligible. If the second group is counted it will be recorded as high. If the third group is included, then the rate will be sufficiently high to occasion genuine concern.

—Report of the Food and Nutrition Board U.S. National Research Council

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Reducing Employee Turnover

BEATRICE HALL

THE APPROACH to this subject of labor turnover will be in the form of a review and discussion of conditions and procedures over which supervisory nurses have control in varying degrees; and for which you have a three-fold responsibility: responsibility from the standpoint of labor cost; the relationship of turnover to the efficiency of your department; and the general welfare of your staff.

We know, of course, that only top management can enunciate certain policies which have a big influence on the turnover rate. Some of these points determined by management are: basic wage rates; working rules and regulations; holiday and vacation policies; promotion policies, working conditions, job security, and so on. Realizing that management contributes its share by setting certain labor policies which will guard against abnormally high turnover, let us consider where the supervisor or department head can make her contribution.

Little can be done about the problem of turnover until we know the causes behind it. It is here that the *exit interview* has its value if it is employed as an honest attempt to isolate the real reasons employees are leaving; and if it is to serve as the first step towards correcting any unfavorable conditions which may be revealed. The findings of those who have made an analysis of employee turnover show that there are four major causes:

1. Improper selection and placement.
2. Poor induction.
3. Inadequate training.
4. Faulty supervision.

Mrs. Hall is personnel manager in the restaurant division of The T. Eaton Co. Ltd., Toronto.

Accepting these findings, let us discuss the advantages of *good practice* in connection with the above procedures.

SELECTION AND PLACEMENT

This is, of course, the responsibility of the personnel or employment office. Each job has its own combination of special requirements, the first step in selecting personnel being to determine these requirements. It is here that job analysis has its value, giving proper job descriptions with a complete and accurate analysis of what a job or position demands. The responsibility of the employment office is to match the strengths and weaknesses of the candidate against the requirements set up for the job in question. Nursing supervisors know full well the cost, not to speak of the headaches, resulting from poor selection. An employee improperly placed is invariably an employee lost to that department, through personal discouragement, transfer, or discharge. Primarily, then, the problem consists in determining where the individual can work best, thereby finding greatest satisfaction for himself and producing most efficiently for the department. It should be noted that when an employee is in a position above his ability level, the strain of the work makes him unhappy. When he is placed below his level, boredom makes him dissatisfied. Either of these conditions can and will lead to lowered morale, lower production, or an increased "leave-rate."

As this article deals primarily with the supervisor's responsibility for labor turnover, we will not discuss the principles of good interviewing, or the use of aptitude or qualification tests, which are, after all, subjects in themselves.

Induction

The heart of the turnover problem is the new employee. After an employee becomes settled in her job, makes friends and feels at home, she is more likely to stay with you. In fact, *the turnover curve declines steadily as the length of the employee's service increases.* It is, therefore, most important that greatest care should be taken to ensure the proper orientation of new staff. Why? There are three reasons, all of which are important to the supervisors who are responsible for the employee's activities:

1. *Your responsibility for the welfare of your staff.* The employee's problems, whether directly or indirectly related to her job, are your responsibility and those related directly to the job are particularly urgent during the induction period.

2. *The relationship of turnover to the ultimate efficiency of your department.* Labor turnover must be cut to a minimum if you are to maintain a stable, efficient working-force. The war years demonstrated the hazards of working with transient, untrained personnel, resulting in inefficiency and lowered per capita production.

3. *The cost entailed in high turnover.* We all know that selection and training of employees is expensive. The cost involves not only the initial introduction to the working-force, but the uncertainty of subsequent success makes it possible that the initial cost of hiring will all be wasted. The following estimates, quoted from Vitelos "Industrial Psychology," show comparative initial costs:

(a) Inexperienced workers who have no previous experience.....$239.

(b) Semi-skilled workers with previous experience, but no knowledge of the job to which they are assigned.....$190.

(c) Workers skilled in operations for which they have been hired; employees who are rehired; workers transferred from other companies.....$24.

The fact that many costs in connection with hiring and training are hidden and difficult to determine makes them none the less real. Such cost will, of course, take into consideration the increased liability of damage to equipment, increased waste of material, and the slowing up of production.

The welfare of your staff, the relationship of turnover to the efficiency of your department, and the cost involved in high labor turnover constitute sufficient reason why supervisors are justified in setting up and carrying out procedures which will contribute to lower turnover rates. It is not my intention to outline definite induction procedures, but only to point out the hazards of poor induction and to generalize on the objectives of good induction. I believe that definite induction procedure should not be set up within a department until there has been full discussion and analysis of the specific needs of each division. Only in this way can plans be outlined which will meet the needs of all.

Admitting that the heaviest turnover is among new employees, and knowing that anything which can be done to get the employee started on the right foot is bound to be reflected in a reduced "leave-rate," it should be the supervisor's objective to orient and acquaint the new employee with the organization, her department, her work, and the benefits and privileges enjoyed by the employees, not forgetting her responsibility to the organization itself.

Where then does this responsibility begin? In making the initial selection, the employment office is the first point of contact. Care should, therefore, be taken at this point that the first impression created is a favorable one. Here the employee should be given the following information:

1. The duties and responsibility entailed in the job in question.
2. Working hours.
3. The rates of pay and method and date of payment.
4. Information regarding the department to which the employee is being assigned.
5. Information regarding uniforms and locker service available.
6. General information regarding organization policy as required or requested by the new employee.

The employment office, or supervisory nurse in this instance, is in most cases also responsible for the initial introduction of the new employee to the department head or her

assistant. From here on the department assumes the responsibility for induction. Subsequently the department head or supervisor is responsible for the further introduction of the employee to her specific work assignment — i.e., it is her duty to assure a proper introduction to the person in charge of the division in which the new employee will be working. *Careful selection and training of sub-division heads will do much to assure proper handling at this point.* It is here that some analysis should be made of the personal reaction of the employee when going on a new job, as it is at this point in the induction that the employee's tension and apprehension are often at their highest. Everything is new and unusual. Many questions and doubts assail her — some petty and inconsequential, which will be answered automatically, others extremely important. It should be noted that the more ambitious and anxious an employee is to please, the more likely she is to be nervous and apprehensive during the induction period. Extreme nervousness during the first few days is no indication of lack of ability, but it may be built up into disaster if handled carelessly!

Such induction is not a normal procedure. It is merely an honest endeavor to make the employee feel at home, and to provide her with information regarding the department personnel, policies, working hours, relief periods, the location of the lunchroom, rules regarding overtime, etc., the lack of which adds up to a feeling of confusion and a sense of strangeness and loneliness when one goes on a new job. Its absence tends to a *high "leave-rate"* within an organization — a fact which justifies any time and effort involved in the building up of a procedure which will guard against such loss of man-power.

Training

Work assignment and training are generally under the direction of the sub-division supervisor or head nurse. We should consider briefly her responsibilities in this matter, discussing the part it plays in the induction period, and its bearing on the welfare and job satisfaction of the employee.

Great pains should be taken, when introducing a new employee to whoever is to be immediately responsible for her work, to explain the previous experience and skills possessed by the newcomer so that the person in charge can be sure that the new worker is being placed to the best advantage. Every care must be taken that the job instructions, whether written or verbal, are clearly given and fully understood. This is often neglected, resulting in spoiled work and embarrassment to the new employee. It is better to err on the side of giving too much instruction than too little. The methods of training and length of training period will depend upon the type and complexity of the job but, regardless of its demands, should be well planned, properly supervised, and subject to check-up. A new employee should never be left in doubt as to what to do next, or how to do it. *The cardinal sin is that she should not know to whom to go for her instruction.* Time and time again, an exit interview will reveal that this is cause for losing a new employee. *Supervised instruction and adequate training are, therefore, major factors in the control of labor turnover.*

This initial training is most important but training, to be adequate, must not stop at this point. It should be a continual process to assist the workers to develop their ability so that they can progress within the department. Its dividends will be shown in greater department efficiency and satisfied staff.

Supervision

A potent cause of turnover is friction between employee and supervisory staff. When termination or exit interviews are properly handled, the facts about poor supervision may be revealed. The interrelationship of high production and good employee-employer relations should, therefore, be stressed. There can be no separation of the two if a department is to achieve maximum efficiency.

Skill in human relations is always

a primary factor in positions which involve the direct handling of people. Briefly, this aspect of an individual is portrayed most readily by the following: an adequate sense of humor; a friendly manner; ability to express ideas clearly; a sincere enthusiasm shown for contacts with employees; ability to adjust quickly to the level of a group; and the ability to lead others to her point of view. *The extent to which a supervisor has these qualities will be the measure of her effectiveness in holding her staff.*

Attitude Studies

A recent approach in Canada to the problem of reducing labor turnover is an attempt to learn what the employees want. What is it they want in life? Is it merely the right to earn a living, to make money? Many think that it is and base their whole philosophy of management upon that thinking. Studies of human motives disprove this belief. Today we are finding that what employees want more than any other thing is *security.*

A survey was conducted by a national organization in the United States to determine which factors employees considered most important. The following tabulation will show the relative importance attached by employees to the different conditions of employment:

1. Job security, insurance and saving plans, old age pension – 90%
2. Opportunity for advancement, training and education – 89%
3. Medical treatment, cafeteria, recreation, etc. – 87%
4. Pride in company, admiration for boss – 82%
5. Personal help and attention from the supervisor, congeniality – 71%
6. Wages, bonuses – 69%
7. Working conditions – 43%
8. Employee representation plans – 35%
9. Chance to show individuality, responsibility – 30%
10. Vacations with pay – 23%
11. Hours of work – 15%
12. Pride in work – 12%

Note that 90 per cent placed job security first, whereas only 69 per cent mentioned wages and bonuses.

An American firm of industrial engineers also studied this problem and checked thousands of office and factory employees to find that the employees wanted the following:

1. To feel that their livelihood is secure, that they will not become objects of charity in later life.
2. The right to feel that they are important to the organization of which they are a part. They want to be more than a "cog" in a machine.
3. Appreciation for the things they do well, for the extra effort they put forward to further the success of the organization. This appreciation need not be monetary but it must have some form of recognition.
4. Treatment which will enable them to maintain their self-respect. This is not just vanity. It is the pride we all feel in whatever we do. It is important to do these things well.
5. Understanding, on the part of those in authority, for the personal problems which engage the employees' thoughts and attention. To be sure, they may be trivial to others but to the employees they are very important indeed.

Summary

These factors are recorded in more general terms, but they embrace the same thinking and give emphasis to what might be termed the "uneconomic needs" of workers. To give sincere effect to these factors calls for more than an understanding of human nature. It calls for procedures which will permit those responsible for the personnel work to do a human engineering job. Among these procedures are those just reviewed on the basis of their relationship to controlling labor turnover. They may be summarized as:

1. *Job analysis* — in its use as a basis for proper selection and placement — i.e., complete job description and breaking the job down into elements, so that it is definitely known what qualities are required to fill each job successfully.
2. *Proper induction procedure* — in its relationship to labor turnover, departmental efficiency, and employee satisfaction.
3. *Wise supervision* — the kind that will bring out the best not the worst in people. Human engineering means building employees who will be so enthusiastic about their jobs

that they will motivate themselves and expand beyond their present level.

4. *Adequate training programs* — not just the superficial training received when an employee takes over a new job, but a continual process to assist the employee to find herself and to develop latent qualities and potential abilities.

Even when all these procedures are observed, the turnover problem will always come under the heading of unfinished business. It is something, therefore, which requires day-to-day adjustment, day-to-day realignment, with continued observance to watch any change in levels if it is to be controlled within a department.

Selection, induction, training, and supervision all have their part to play. If turnover is inordinately high it is the supervisor's duty to find out what part of the program is falling down. Continued high turnover in any one department warrants investigation. Such investigation, together with properly handled exit interviews, should shed a good deal of light on the real reasons employees are leaving. It is the supervisor's responsibility to remedy those over which she has control. Domestic responsibilities, illness, job-jumpers and such are things over which she has little or no control, but those coming under the category of *poor department procedure and administration* are definitely her responsibility.

Changing Emphasis

The increasing prominence of the diseases characteristic of middle and later life requires a reorientation in the viewpoint and the activities of health officers and physicians to meet the changing needs of their communities. The public health and medical professions, having largely solved the major problems of sanitation and of communicable disease control, are now ready to wrestle with the even more difficult problems of conserving life and health in middle-aged and older people.

The cardiovascular-renal diseases, which lead as causes of death and disability at the older ages, provide a fertile field for life conservation activities. In the past, the public health movement has hoped to prevent heart disease mainly as a by-product of the attack on syphilis. The future program must give greater attention to cases of degenerative origin. Much can be done to prevent heart disease among adults and to prolong the life of cardiacs through a well-planned and co-ordinated educational program, stressing the importance of good living habits and the dangers of overweight and overstrenuous physical activity. Insurance studies on heart disease show clearly that overweight people suffer heart damage earlier and succumb earlier than do people of average or below average weight.

Cancer is second only to heart disease as a cause of death in our country. Under present conditions of mortality, one out of every nine white males born and one out of every seven white females born will eventually die from cancer. The tragedy is that far too many cases are discovered at the later stages, when little can be done for the patient. There is convincing evidence that the cancer problem is by no means an insoluble one, even in the present state of our knowledge. The American Cancer Society estimates that the current mortality from the disease can be cut by one-third through the early detection and adequate treatment of cases.

Diabetes is another important disease of later life against which further progress can be made through a sound public health program. Diabetes is unique among the diseases of middle and later life in that insulin provides a specific means of control. Recent studies indicate that about 3 per cent of the total population will eventually become diabetic.

There are a number of other common causes of sickness and death among older people which merit greater attention. These include: tuberculosis, pneumonia, mental disease, nutritional diseases, and accidents. In approaching these many problems, it is essential that the efforts of the health departments, private physicians, organized medical groups, and voluntary health and safety agencies be co-ordinated at the local level. This should be the primary responsibility of the health officer, who is the logical leader in developing effective health services for his community.

— *M.L.I. Statistical Bulletin*

Private Duty Nursing in the Home

MAY A. NILES

ONE OF MY FIRST experiences of private duty nursing in the home was when I was a very fresh graduate. It was an emergency call to a suburban home. A baby was due to arrive any minute. I arrived first, but stood aghast as I gazed around the room. The baby simply could not come here! No labor room equipment — no sterile supplies — not even a sterile towel! Just then the lady doctor appeared. In answer to my frantic queries, she answered tersely, "Newspapers — get newspapers." The baby arrived — survived, and I was initiated into the value of newspapers in the home. Made up into paper bags, they are almost indispensable. As a substitute for rubber macintoshes, they save many a mattress from ruin. A pad of them made with rolled edges, and a piece of ironed cloth on top, made a placenta basin — even a bed-pan in an emergency. They can be made into sputum cups for infectious cases, and arranged cone-shaped over a jug — an inhalator.

There was Mrs. B who was more concerned over the condition of her furniture than her own illness. I had hardly arrived when I heard the tale of "the other nurse" who had put a glass of water on the dresser and made "that ring on it." It was not long before I realized I, too, was thinking more of the furniture than of Mrs. B. So I covered it with a cloth, then pads of newspaper, a dresser scarf, and forgot about it.

Home nursing is necessarily different from hospital care, but so many substitutes can be made for essentials, that with a little ingenuity and imagination it can be just as convenient — and successful. A Fowler's bed can be easily made by putting studio couch cushions under the mattress at the top of the bed and a pillow under the patient's knees. A chair turned upside down with its back to the patient's back is an excellent back-rest. Be sure to protect the head-board with pads of cloth or newspaper, or it will be exhibit "A" for the next nurse!

An ironing-board across the bed supported on the backs of two chairs — the kind with rungs up the back — makes a good bed-table. A cardboard carton at the foot of the bed will keep the weight of the bed-clothes off the toes. A cream pitcher makes a substitute for a feeding cup. A child loves it but we would hope he doesn't keep up the habit when he is well again. Dishpans will do duty for sterilizers and quart sealers for baxters. Spoons for tongue depressors can be found in any kitchen.

Nursing in the home brings a threefold responsibility — to the patient, the family, and the profession. Decisions regarding the patient's condition have to be made by the nurse alone, which in the hospital would be shared by the staff.

Regarding the family, housekeepers, and cooks, it is well to remember the scriptural injunction to be as "wise as a serpent and as harmless as a dove." I remember once eating "spare-ribs" for five days in succession, as they were the only fare on the menu. It kept the cook sweet — if not the nurse.

Sometimes compromises just have to be made. There was Mrs. A whose husband I nursed. She refused to

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sleep alone the night he died. I offered to stay and sleep in the next room — on a cot in her room — in a chair by her bed! No, the nurse would have to sleep *with* her! The sons could not understand my refusal, and matters finally began to assume all the proportions of an international situation — so I compromised, and we slept "head to foot." Everybody seemed satisfied — the family, of course.

Home nursing is more difficult than in hospital. Things are not handed out to one on a sterile platter, sometimes not even a clean one, but the human interest seems far greater. As one daughter expressed it to me, "My burden seemed to roll off me on to you, when you came in." It is not a burden to us. It's our vocation, and as such is our responsibility to our patient and to the whole profession.

In these days with the acute shortage of nurses, and hospital beds, private duty nursing in homes is not only essential to the patient but a source of gratification to the nurse.

How Do You Read?

EUGENIE GLATZL

To many people, reading is a pleasant occupation which can be indulged in according to one's own taste. To the nurse, it is also a special tool to build proficiency in her vocation.

Nursing implies far more than the practical applications of therapy. Nurses have a responsibility, particularly in the public health field, to interpret modern medicine and health to the individual patient, the family, and the community. To do an effective job, it is necessary to keep abreast of new discoveries, ideas, and methods of practice constantly being published as scientific research advances. The nurse as a teacher has a unique opportunity.

A nurse, of course, must follow the developments in her field through reading professional journals and books. However, she may also wish to round out her reading background as a whole by reading in such fields as economics and sociology, for example. These help her to relate her profession to the whole social organization by increasing her knowledge about people and sections of the country—local and national. Whatever the aim, a definite plan is needed.

What is good reading? Among the wealth of good books, how can she choose those which are of vital importance? The choice will naturally be influenced by interest. However, there are two essentials to look for in a good book. First, it must be authentic; and, second, the subject matter must be adequately treated. In selecting a book, it is important to note the author's qualifications, the sources used, and the reliability of the publisher. Other points to determine are the principal topic of the book, whether additional subjects are covered, and any limitations in scope.

With limited time to read, it is essential to choose books that will result in the most profit. We are all familiar with Lord Bacon's classification of books—some "to be tasted, others to be swallowed, and some few to be chewed and digested; that is, some books are to be read only in parts, others to be read, but not curiously; and some few to be read wholly and with diligence and attention." When reading to acquire knowledge, therefore, a few rules of learning should be kept in mind —first, to read the author's aims as stated in the preface and introduction; second, to concentrate attention on a passage, understand its meaning, and mentally summarize its contents before going on to the next; finally, to evaluate the book—its truth and importance—according to the yardstick of judgment acquired from previous reading and experience.

Usually it is necessary to *make* time to read. But it pays dividends in personal satisfaction and increased knowledge. Half an hour daily will bring a rich reward in a surprisingly short time. As Sir William Osler so aptly said, "With half an hour's reading in bed every night as a steady practice, the busiest man can get a fair education before the plasma sets in the periganglionic spaces of his grey cortex."

— *The Quarterly Bulletin, M.L.I.C.*

It is in the power of man to make all infectious diseases disappear from the world.—PASTEUR

Aux Infirmières Canadiennes-Françaises

Les Médicaments Nouveaux

ROGER R. DUFRESNE, M.D.

LES MÉDICAMENTS nouveaux ont, de tout temps, sollicité la curiosité et retenu l'attention. Ils doivent, la plupart du temps, ces égards à leur nouveauté même; ils en souffrent aussi parfois. Pour les sceptiques, les innovations thérapeutiques ne méritent que de la méfiance. Les enthousiastes, eux, ne demandent qu'à croire aux vertus de la nouvelle drogue qu'on leur vante et, selon le conseil d'un ancien, se hâtent de l'employer pendant qu'elle guérit. Bon nombre de médicaments et de modes thérapeutiques ont, ainsi au cours des siècles passés, connu des fortunes diverses qu'ils n'ont pas dues à leur seule valeur. L'histoire de la thérapeutique n'est pas toujours glorieuse — elle est humaine. Depuis qu'un homme s'aventurat à traiter son semblable et que celui-ci eut assez confiance pour le laisser faire, les progrès de la science et de l'art de guérir ont exploité, avec plus ou moins de succès, l'ambition des thérapeutes et la résignation des malades! Mais, depuis le début de notre siècle surtout, médecins et patients ont profité des découvertes de la science, et les progrès de la dernière décade en particulier furent tels qu'aucune nouveauté, si extraordinaire soit elle ne peut plus surprendre ceux qui espèrent tout des possibilités de la chimie et de la physique contemporaine.

On avait, aux E.U. en 1910, fait une enquête auprès des professeurs de thérapeutiques et des cliniciens réputés de l'époque, afin de découvrir les dix médicaments que l'opinion générale reconnaîtrait comme les plus utiles. La liste avait été la suivante: l'éther, la morphine, la digitale, l'antitoxine diphtérique, le vaccin antivariolique, le fer, la quinine, l'iode, l'alcool, et le mercure. En 1945, on a voulu reprendre l'enquête et refaire la liste et voici quelles étaient les étoiles à ce moment: (1) La pénicilline et les sulfamidés, représentant la médication antibiotique; (2) le sang et ses dérivés; (3) la quinine et la quinacrine; (4) les anesthésiques et les sédatifs de l'éther au curare et de la morphine aux barbituriques; (5) la digitale; (6) les arsénicaux; (7) les sérums et les vaccins; (8) l'insuline et l'extrait de foie de veau; (9) les autres hormones; (10) les vitamines.

On conviendra que le thérapeute d'aujourd'hui est favorisé. Les armes qu'il manie sont infiniment plus efficaces que celles de ses prédécesseurs. Elles sont aussi souvent plus dangereuses, d'autant plus que dans sa hâte d'aller vite et de guérir rapidement son malade, le médecin peut oublier qu'il a d'abord le devoir de ne pas nuire.

Un médicament peut provoquer des réactions diverses. D'abord, des réactions utiles, celles que nous désirons et qui servent à modifier passagèrement la fonction d'un tissu ou d'un système quelconque de l'organisme. Des médicaments à réactions utiles et importantes, des médicaments efficaces — nous en avons et de plus en plus, et nous devenons aussi de plus en plus audacieux dans leur emploi. Si les voies d'absorption normales s'avèrent inadéquates, nous n'hésitons pas à introduire la substance active sous la peau, dans les muscles, directement dans la circula-

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tion, ou dans n'importe laquelle des cavités de l'organisme. Nous obtenons ainsi des résultats surprenants, assez souvent favorables parfois nuisibles, voire même dangereux; car il faut bien penser aux réactions nuisibles qui font parfois payer cher l'enthousiasme. Bien que de médicaments véritablement actifs ne sont pas dangereux par certains côtés. Reprenons sous cet aspect la liste que nous avons donnée plus haut des médicaments les plus utiles en 1945. Il nous faudra d'ailleurs déjà la compléter ou la modifier pour qu'elle représente bien les progrès faits depuis quatre ans.

La médication antibiotique a une valeur indiscutable mais la plus inoffensives des substances de cette catégorie — la pénicilline — peut causer de désagréables surprises, allant des réactions cutanées avec fièvre et arthralgies jusqu'aux troubles mentaux sans compter les réactions par contact direct. La streptomycine donne les mêmes ennuis et surtout perturbe parfois sérieusement l'équilibre et l'ouie des malades qui en reçoivent des doses importantes et prolongées. Il faut ajouter que depuis deux ans environ, on a tendance à diminuer les doses de ces antibiotiques; les résultats sont aussi satisfaisants et les inconvénients moindres.

Le sang et ses dérivés ont pris en thérapeutique courante une place d'honneur. Il est recueilli et distribué par les "banques" de nos hôpitaux ou de certaines grandes organisations. Le nombre des donneurs n'est pas illimité et le sang total s'altère rapidement; aussi, le fractionnement de ce sang total, qui permet une conservation prolongée et des usages multiples, a-t-il introduit en thérapeutique des substances biologiques jusque là inexploitées et dont l'importance et le nombre ne pourront que s'accroître: plasma, sérums, suspension de globules rouges, globine, thrombine, fibrine, fibrinogène, gamma globuline, albumine du sérum, etc. Mais, faut-il le rappeler, les transfusions ne sont pas sans danger — danger des réactions pyrogènes et allergiques, et surtout danger d'hémolyse ou de collapsus circulatoires parfois mortels. Il sied sur ce chapitre de dire un mot des anticoagulants — héparine et dicumarol. On admet généralement leur utilité dans le traitement de tous les phénomènes d'oblitération veineuses ou artérielles avec leurs diverses conséquences, mais il faut penser qu'en les employant on compromet la défense naturelle de l'organisme contre l'hémorragie.

A propos des anesthésiques et des sédatifs, mentionnons les divers succédanés de la morphine — démérol, métopon, méthadon, etc.— que l'on a introduits depuis quelques années et qui s'efforcent d'être des remplaçants utiles mais encore imparfaits de l'incomparable produit du "pavot somnifère."

L'insuline et l'extrait de foie de veau introduits en thérapeutique vers la même époque ont de multiple points de ressemblance. Ils sont indispensables aux malades qui souffrent de diabète ou d'anémie pernicieuse, autant pour les maintenir en équilibre que pour les aider à traverser les accidents aigus qui compliquent souvent leurs maladies. Mais à l'extrait de foie de veau on a ajouté depuis quelques années l'acide folique dont les succès du début ont fait espérer plus qu'il ne pouvait donner. On parle maintenant de la vitamine B_{12} qui accomplirait elle aussi des merveilles dans l'anémie pernicieuse. On parle aussi des dérivés "du gaz moutarde" qui semble venir à bout, passagèrement et non sans dangers, de certains processus tumoraux. Cette médication représente assez bien l'audace thérapeutique de notre époque. On introduit, par la voie intraveineuse de préférence, un poison quelconque dont les effets immédiats sont habituellement désagréables et dont on espère que les résultats ultimes seront plus satisfaisants que dangereux.

Le médecin à la page ne peut ignorer les hormones et les vitamines! Celles-ci ont pris en thérapeutiques une place nouvelle mais on ne se contente plus de les recommander comme compléments indispensables d'une alimentation souvent insuffisante. On les utilise le plus souvent à forte dose

dans un certain nombre d'affections qui ne semblent pas dépendre à priori d'une avitaminose quelconque. Et c'est ainsi que l'acide folique, le chlorure de thiamine, l'acide nicotinique, la pyridoxine, la vitamine E entre autres, sont devenues des armes thérapeutiques nouvelles grâce à des propriétés qu'elles ne semblent pas devoir uniquement à leurs fonctions normales de biocatalyseurs.

Mais là aussi, il faut distinguer entre l'utilisation rationnelle, l'expérimentation raisonnable, et l'abus inconsidéré qui sème le doute et le discrédit. Ce danger n'est pas nouveau — il existe depuis toujours. Mais à notre époque de progrès rapides et parfois sensationnels et d'amers désenchantements, il importe d'en être plus averti que jamais et d'avoir pour tout ce qui est nouveau l'attitude de l'homme sage, qui sait réserver son jugement et d'autre part ne s'embarrasse des préjugés qu'entraînent l'âge et l'expérience!

In The Good Old Days

(*The Canadian Nurse, February, 1909*)

In an effort to encourage nurses to increase their qualifications by enrolling for courses at Teachers College, Columbia University, one article lists the expenses likely to be incurred as follows:

"The cost of tuition and fees is from $150 to $170; room, board and (plain) laundry, $280 to $400 — $310 is a good average — for the academic year; a very liberal allowance for books, $20; and then there is car fare on excursions to various hospitals, etc., amounting, probably, to $7.00 or $8.00. The other expenses of regular living are what one makes them and should not be called college expenses."

"Lately I have seen much discussion on the advisability of doing away with the three years' course. I think a compromise would be better, thus: give the probationers a three months' course in the usual duties of probationers, supplemented with simple lessons in anatomy, so that when accepted after three months, and told to put a poultice on the base of the left lung, she'll know not only how to make a poultice, but where to put it without the supervision of the head nurse. Then give them two years' ward work with the usual lectures and classes and wind up with three months in household economics. Just how much beefsteak to order for a household of three or how many potatoes to boil for same, how to prepare clothes for the wash 'lady' and general cooking, etc., for a nurse must know these things, especially if it is the mother who is laid by."

"The Winnipeg School Board has decided to institute a system of medical inspection of school children. This will necessitate the employment of one or more nurses. No appointments have as yet been made."

"The new Calgary General Hospital has now its roof on, and the work of finishing is being proceeded with from inside. The opening is hoped for in August. When fully completed and equipped there will be 225 beds."

"Miss Hersey, who has been acting superintendent of the Royal Victoria Training School for Nurses, has been unanimously appointed to the permanent position of Lady Superintendent."

"A fear of pauperizing people has been a hindrance in meeting the need for skilled nursing in the homes of the workingman . . . Pauperism as a vice cannot be laid alone at the door of the poor; for what is pauperism but a desire to obtain something for nothing? It seems as if even those who have wealth, unless they are independent and honest to the core, try how much they can obtain for nothing!"

Nitrogen Balance

A positive nitrogen balance is essential to the processes of immunity and tissue repair. Proteins may be replaced as they are used in the body by a diet rich in eggs, cheese, and other easily absorbed proteins. Transfusions of plasma furnish an easy means of replacement. Intravenous administration of amino acids can maintain a positive nitrogen balance even in the presence of excessive loss.

— *Selected*

Nursing Profiles

Matilda Elizabeth Fitzgerald, who has guided the destinies of the Registered Nurses' Association of Ontario as the capable, steady, and assured secretary-treasurer since 1927, has retired.

This form of executive work was a new venture for the gracious lady who on a June day opened the first association office. She had graduated from the Hospital for Sick Children, Toronto, thirteen years before and had spent all but one of the intervening years on the staff of H.S.C. She had been a ward supervisor — in charge of Lakeside Home — second assistant in the School office — instructor. A year of private duty had rounded out her experience before the new door-way opened.

In the twenty-one years that have flown, Miss Fitzgerald met each new challenge of responsibility with courage and the elasticity that only her Irish inheritance could have given her. Possessed of a remarkable memory, she had the gift of remembering nurses' names — a decided asset as the membership of the R.N.A.O. expanded. "No organization was ever more truly the product of one woman's devoted service, yet so clear was Miss Fitzgerald's concept of her relationship to her work and of her responsibilities as a servant of the Association, that she was incapable of any selfish possessiveness."

The hearty good wishes of nurses in all parts of Canada follow Miss Fitzgerald. We wish her supreme happiness and good health in the years that lie ahead.

The new secretary-treasurer of the R.N.A.O., **Florence Harriet Walker, B.A., B.A.Sc. (Nursing),** is thoroughly conversant with the workings of this expanding organization. Since January, 1945, she has been the associate secretary and editor of the R.N.A.O. *News Bulletin*. A graduate of the Hamilton General Hospital in 1926, Miss Walker received her degrees from the University of B.C. For three years she served as instructor in the school of nursing at H.G.H., then accepted a position on the nursing administration staff at the Vancouver General Hospital. In 1938 she was appointed supervisor of the Infants' Hospital, Vancouver. She joined the staff at the National Office of the C.N.A. in 1943 as assistant secretary.

This broad background of experience has been augmented by the very active part Miss Walker has always played in nursing association work. During the time she worked in B.C. she was a member of the Council of the R.N.A.B.C. for six years, honorary secretary for four. She is a woman of many interests,

MATILDA FITZGERALD

Hubert Beckett

FLORENCE WALKER

reading and music predominating. Miss Walker's only complaint is that no day is long enough for all the things she would like to do and accomplish.

Announcement is made of the appointment of **Alice Sher** as assistant executive secretary to the headquarters staff of the I.C.N. Miss Sher graduated from the Latvian Red Cross Nursing Training School, Riga, Latvia, in 1925. She then spent some time in England studying public health nursing at Bedford College and a four-month course under Dr. Truby King at the "Babies of the Empire" Training Centre, London.

She returned to Latvia where she held a responsible position in the Latvian Red Cross Headquarters, Public Health Division, organizing and supervising public health centres and lecturing on maternity and child welfare and public health at the Latvian Red Cross Nurses Training School in Riga. In 1941, she became chief nurse of the Latvian People's Aid, where she organized the three-month course for nurses' aides. In 1944, she became nursing adviser of the Health Department of the Latvian Relief Organization in Germany. Following the war, she joined the staff of UNRRA as deputy nursing adviser in Germany, later becoming president of the D.P. Nursing Advisory Committee, Nursing Division of the International Refugee Organization.

In addition to her own native language, Latvian, Miss Sher speaks fluent German and English. She will be a tremendous help to the headquarters of I.C.N.

Each biennium, the president of the Nursing Sisters' Association is elected from the province in which the next biennial meeting is to be held. With Vancouver as the scene in 1950, the members of the N.S.A. in B.C. have duly chosen **Lillian MacMillan** as their president.

Miss MacMillan was born at Baddeck, N.S., and after receiving her education in B.C., entered the school of nursing of St. Luke's Hospital, Bellingham, Wash. During W.W.I. she served with the United States Army Nurse Corps. Upon receiving her discharge, she joined the staff of the University of Washington where she was supervisor in public health nursing and social service. For two years she was superintendent of

LILLIAN MACMILLAN

nurses at the General Hospital, Everett, Wash., returning to Canada in 1930 as superintendent of the Juvenile Detention Home, Vancouver. Nine years later she became matron in charge of the Women's Division of the Oakalla Prison Farm.

When the South African Military Nursing Service was organized, Miss MacMillan enlisted and 1942-45 served in base hospitals in South Africa and on the hospital ship *Amra*. She is presently engaged as follow-up nurse with the B.C. Cancer Institute.

Ruth Thompson has assumed her duties as director-in-chief at Victoria Hospital,

RUTH THOMPSON

SISTER JULIETTE BARCELO

London, thus initiating a new position which was created to correlate the nursing service and nursing education programs. A B.Sc. graduate of the University of Alberta Hospital in 1930, Miss Thompson recently completed the work for her master's degree in administration in schools of nursing.

Following graduation, Miss Thompson went to the Lamont (Alta.) Public Hospital as instructor and assistant matron. In 1935 she returned to the University Hospital, Edmonton, as clinical supervisor. Three years later she was appointed director of nursing service at the Belleville (Ont.) General Hospital and remained there until she enlisted in the R.C.A.M.C. She saw active service aboard hospital ships in the North Atlantic.

After her release from the army, Miss Thompson was named assistant matron at University Hospital, in charge of nursing services at Mewburn Pavilion, D.V.A.

A graduate nurse who became a dietitian and has published two textbooks on dietetics, **Sister Juliette Barcelo, r.h.,** has recently been appointed superior of Notre Dame Hospital, Biddeford, Maine. Born at St. Scholastique, Que., Sister Barcelo trained at Hotel Dieu, Montreal, graduating in 1924. She was in charge of the hospital laboratories until 1933 then branched out into her dietetics work, receiving her B.S. from the College of St. Theresa, Winona, Minn., to supplement the B.A. she already held from the University of Montreal. She was in charge of the dietetic department at Hotel Dieu from 1941 until her present appointment. Sister has spent all her leisure time devising ways and means of improving the dietary system in relation to the welfare of the patients.

Macdonald, Toronto

JESSIE YOUNG

Jessie E. Young, who took up her duties as director of nursing at the Kitchener-Waterloo Hospital, Ont., last summer, graduated from the Toronto General Hospital in 1933. She secured her certificate in ward administration from the University of Toronto School of Nursing the following year and returned to T.G.H. as head nurse. Five years later she became surgical supervisor. In 1940, she went to Port Arthur General Hospital where for two years she was instructor, then served three years as assistant superintendent.

University work lured Miss Young to Columbia where she qualified for her B.S. degree in 1947. Following graduation, she joined the staff of Hamilton General Hospital, serving there as educational director for a year.

Elva C. M. Honey, A.R.R.C., has been appointed Montreal Area nursing consultant with the D.V.A.

A member of the 1934 graduating class of the Winnipeg General Hospital, Miss Honey was a head nurse there for four years. She enlisted as a nursing sister and went overseas in June, 1940, later serving as assistant matron in Britain, Sicily, and Italy. She became principal matron of No. 14 Canadian General Hospital, situated at Perugia, Italy, in 1944.

After V-E Day Miss Honey returned to Canada for discharge and registered at McGill School for Graduate Nurses in the administration in schools of nursing course. When she graduated with her bachelor of nursing degree in 1947, she was appointed an assistant to the director of nursing at the Montreal General Hospital.

W. Gordon Mitchell

MRS. L. H. FISHER

MARGARET E. GRANT

Miss Honey will make her headquarters in Montreal and will co-ordinate the nursing service and staff education programs of the various D.V.A. hospitals in that area.

Frances (Reed) Fisher, who graduated from the Montreal General Hospital in 1912, is director of the Montreal School for Nursing Aides. Mrs. Fisher engaged briefly in private duty nursing, then went to Wilmington, Delaware, first as charge nurse in the operating-room, later as director of nursing at the Delaware Hospital. Returning to M.G.H. in 1920, she was assistant to the superintendent of nurses, later, for six years, in charge of the education department. Her marriage in 1929 to the late Rev. Lawrence H. Fisher terminated her active nursing duties though she participated with interest in the alumnae associations of both the Montreal General Hospital and the McGill School for Graduate Nurses where she had secured her certificate in teaching in schools of nursing.

Margaret Ethel Grant, a native of St. Marys, Ontario, who graduated from the Saskatoon City Hospital in 1923 and commenced her duties with the Saskatoon Health Department shortly thereafter, has retired. She was always a keen student of matters relating to her chosen field and took every opportunity of keeping pace with new advances in public health by reading and attending various courses throughout the years. She always took great pains in teaching student nurses who were sent for instruction to the well-baby and other clinics from the Saskatoon hospitals and the university. In May, 1948, she took over supervisory duties in the City Health Department, even though the assumption of these responsibilities put a great tax on her strength. Nevertheless, she faced all problems with a serene, confident manner.

Miss Grant was active in nursing affairs generally, serving on the executive of the City Hospital Alumnae and on the local and provincial executive of the Saskatchewan Registered Nurses' Association for a number of years. She embodies all the highest ideals of a truly Christian nurse — kindly, forebearing, and sympathetic — and she will be missed by her associates with whom she worked for so many years.

In Memoriam

Annie Beckwith, a native of Nova Scotia, died at Memorial Hospital, Worcester, Mass., on October 15, 1948, at the age of eighty-six. Miss Beckwith had received her professional training in that hospital many years ago.

Catherine (Charbonneau) Elvin, who graduated from St. Paul's Hospital, Vancouver, in 1927, died on December 7, 1948, at the Royal Columbian Hospital, New Westminster, where she had been night supervisor for the past two years. Mrs. Elvin was in her forty-fourth year.

Mary Jane (MacLean) Falconer, who graduated from the Montreal General Hospital in 1894, died in Halifax on December 23, 1948, in her eighty-sixth year.

Mildred (Lyons) Kent, a graduate of the Moncton Hospital, died suddenly on November 30, 1948, at Bathurst, N.B. Before her marriage, Mrs. Kent had been superintendent of the James Hamet Dunn Memorial Hospital in Bathurst for several years.

Isobel Pearl Miller, who graduated from the Toronto Hospital for Sick Children in 1932, and later took post-graduate work at the Montreal General Hospital, died on October 12, 1948, after a lingering illness. Miss Miller had been a member of the staff of the Shriners' Hospital for Crippled Children in Montreal for six years.

Mary E. Richardson, a native of England who served in World War I in France, died in November, 1948, at Viking, Alta., where she had resided since 1928. Aged seventy-two, Miss Richardson was accorded a military funeral with the impressive ritual of the Canadian Legion burial service.

Kate C. Robinson, who served as a nurse in St. Thomas's Hospital, London, during World War I, died suddenly in Victoria at the age of seventy-three.

Martha Odessa Thompson died in Dartmouth, N.S , on November 10, 1948.

Grace Elizabeth Wood, a nursing sister in Canada during World War I, died in Toronto on December 14, 1948. Miss Wood was a graduate of Victoria Hospital, London, Ont. She was a member of the first graduating class in public health nursing from the University of Toronto. For a time she was on the staff of the Victoria Park Forest School, retiring some years ago because of ill health.

Schoolroom Lighting

More light in the school classroom does not necessarily mean better sight for school children according to *Lighting Schoolrooms*, a 17-page pamphlet published by the U.S. Office of Education.

Although more light is required in many classrooms, the provision of good seeing conditions is as much a matter of reducing glare and of eliminating sharp contrasts in the intensity of lighting.

Brightness differences can be reduced by shielding the lamps, seating pupils so that they will not face windows, repainting walls and ceilings with pastel tints, and using lighter colored furniture and chalk boards.

Streptomycin and Tuberculosis

Reporting on the findings of the subcommittee on streptomycin called by the World Health Organization in New York last July, the experts point out that, while exerting a beneficial effect on several forms of tuberculosis (tuberculosis meningitis, miliary tuberculosis, exudative types of pulmonary tuberculosis, tuberculous laryngitis, tuberculous enteritis, etc.), streptomycin should be considered at its best only as an auxiliary in the general treatment of the disease and that it is partially dependent for its full effect upon other therapeutic measures, such as bed rest, pneumothorax, chest surgery, etc.

Recommendations concerning the daily dosage of streptomycin, methods of administration, and duration of the treatment are included in the report. Emphasis is placed on the fact that there is no single streptomycin regimen suitable for all forms of tuberculosis and that, therefore, each treatment must be designed to meet individual requirements.

The Expert Committee further recommends that streptomycin be distributed by governments only, to institutions, medical centres, and teaching hospitals regularly concerned with the study, diagnosis, and treatment of tuberculosis. The report adds that in view of the potential importance of other chemotherapeutic agents in all phases of tuberculosis control, further work by experts in this field appears indispensable.

Notes from National Office

Nurses and World Health

THE EDITORIAL published in the autumn issue of *The International Nursing Bulletin* has this to say of nursing:

> Without a nursing service a country can never prosper, since the very survival of a country, still more its greatness, depends on its ability to take care of the weaker members of its community; and nursing *is* care — care for the well that they may continue in positive health, and for the sick that they may regain health.

Nursing has achieved international status and because far-seeing nurses a half-century ago organized internationally and have developed the machinery through which to speak authoritatively on behalf of large groups of nurses, the International Council of Nurses has been elected into official relationship with the World Health Organization. This is a proud moment for nurses and nursing. Such a relationship carries with it both privileges and responsibilities.

In the January issue of *The Canadian Nurse* we outlined the major programs selected for action by WHO. Two of these programs — Tuberculosis, and Maternal and Child Welfare — are of particular interest to Canadians and are in areas where nurses can make effective contributions. To quote from the I.C.N. *Bulletin:*

> Nurses, then, must see to it that by all possible means in their own fields of endeavor, and most particularly in those which are "priorities" selected by World Health, they strengthen, develop, and intensify their programs of work . . . In a world which is torn by political differences and where discord between countries is still rife, it is surely significant that international co-operation is still possible on questions of health. Here, too, we can surely make a valuable contribution, for nursing is a profession which knows no barriers of country, race, or color. Based on principles of humanity rather than politics, we nurses have gone far to solve the problem of human relationships at the international level, and are, therefore, in a strong position to advise where international co-operation is an essential factor in promoting World Health.

Great Britain

It will be of interest to Canadian nurses to know one of the outcomes of the "Working Party's" investigation in England. To quote from the *Nursing Times* of November 13, 1948:

> The Government intends to change the constitution of the General Nursing Council and to promote legislation during its present session which will provide for the better training of nurses.

The General Nursing Council is the body set up by statute under the 1919 Act to maintain a register of trained nurses, to be responsible for the standard of the training, the examinations for admission to the register and the professional standards of registered nurses and, since 1943, to perform similar functions for the assistant nurse. The suggestions of the Working Party report are that: (1) Nurse-training units be established to take the place of the present type of nursing school. This proposal suggests the grouping of several hospitals of varied types together under the National Service Boards and Management Committees, thus offering the student a broader program. (2) A director or principal should be in charge of such a training unit as apart from the matron of the nursing service. (3) There should be contact between the training units within each of the Health Service Regions, through Regional Nurse Training Boards or Committees. (4) A Nursing Division at the Ministry of Health should inspect and approve training units.

This last proposal has met with pro-

fessional opposition on the ground that the body responsible for examination and registration of candidates trained by the units should also assume responsibility for inspection and approval of these training units. These proposals may have much in their favor but:

It would be unwise to institute a new scheme as the statutory requirement before it has been tried out and proved satisfactory by experiment.

The inevitability of the student nurse finally achieving student status without sacrificing her practical experience was recently discussed in the British Parliament, as well as the two-year training period. Whether nurses agree with these proposals or not, they must be aware of what is happening and must make sure they have a voice in the making of nursing policies.

Legislation is imminent; the nursing profession must be alert and aware of the potentialities ahead, and must take an active part in achieving the best results.

Have we, in Canada, any need to take heed of this message?

Health League of Canada Annual Meeting

As the Canadian Nurses' Association representative, I attended the annual meeting of the Health League of Canada and sat in on as much of the program as my time would allow. Of particular interest was the afternoon spent on "The need for co-operative action by voluntary agencies," with many well-known speakers participating in the panel.

Similar panels discussed various phases of health such as : immunization and pasteurization, arthritis, nutrition, social hygiene, mental hygiene, and industrial health. I was particularly impressed with the gathering of several hundred at the Industrial Health Section of the program. Somehow or other, the Health League, through their Industrial Health Committee, has been able to reach industrial nurses and get them out to a meeting. Possibly their success can be attributed to the fact that they have brought management actively into the picture. I did wonder, however, whether this rapidly increasing group of nurses are finding greater understanding and assistance from association with sources other than their own professional organizations such as the Canadian Nurses' Association and Canadian Public Health Association. Have the Public Health Nursing Sections been as aware of the apparent success of the Industrial Section of the Health League of Canada as they might be?

The Industrial Health Committee states that its method of obtaining its clearly defined objectives is "to work in support of and in collaboration with federal and provincial health authorities and national or local voluntary trade and professional associations." It publishes *Industrial Health*, a monthly service bulletin which covers a wide variety of topics of interest to members of factory medical departments, management, and plant officials concerned with employee welfare, and might well be kept in mind by the Public Relations Committee if and when the Public Health Nursing Section or the Executive have anything they wish the committee to bring to the attention of industrial nurses.

Respectfully submitted,

HELEN C. MCARTHUR

United States

A report tells of a recent effort to develop effective teamwork. The *American Journal of Nursing*, November issue, reports that early in the year 1948 the American Hospital Association took the initiative in organizing what is now called the Joint Commission for the Improvement of the Care of the Patient. Its purpose is based on the assumption that better understanding of each other by medical, nursing, and administrative staffs will result in better patient care. Membership consists of five representatives from the American Medical Association, five from nursing, and five from the American Hospital Association, including its council on professional practices and representatives acceptable to the Catholic and Protestant Hospital Associations.

I.C.N. Congress Applications

We have just been notified by the Secretary of the International Council of Nurses that application forms deal-

ing with accommodation, etc., for the conference to be held in Stockholm in 1949 will presently be received in National Office. These forms are to be made in triplicate by those proposing to attend the meeting. Two copies should be returned to National Office and one copy retained by the applicant. We have been warned that this will be the biggest conference that has ever been held in Stockholm and that, while a great effort will be made to make everybody comfortable, it is hoped that visiting nurses will not be too hard to please. A very hearty welcome is extended to Canadian nurses by the Swedish nurses.

Special Course in Norway

The following program will be of interest to many:

Course to be held in Oslo prior to the I.C.N. conference in Stockholm, June, 1949: Applications to attend this course should be addressed to Miss Ordrop, president of the Norwegian Nurses' Association, 12 Universitetsgaten, Oslo, Norway.

Monday–June 6 — Arrival.

Tuesday–June 7 — Opening lecture: Geography and history of Norway. Lecture: Cultural life in Norway. Film: Norwegian mountains. Excursion: to Frognersetere.

Wednesday–June 8 — Lecture: Medical services in Norway. Lecture: – – –. Film: "Everybody in Danger." Excursion: to medical institutions.

Thursday–June 9 — Lecture: Nursing in Norway. Lecture: – – –. Lecture: Public health nursing in Norway. Excursion: to training schools.

Friday–June 10 — Lecture: The B.C.G. vaccination. Excursion: to Kringkastingshuset (The Norwegian Broadcasting). Excursion: to Husfliden.

Saturday–June 11 — Visit to an old paper mill. Departure to Stockholm at night. (All lectures will be given in English. Total cost: about £15.)

Committee on Public Relations

With the acceptance of the report of the Public Relations Committee at the biennial meeting, the Publicity Committee and the Public Relations Committee were combined. A detailed report has been received from Christine Livingston outlining the preparation and arrangements for publicity during the biennial meeting and will be invaluable to the committee in the future. Miss Livingston did an exceptionally fine piece of work for the association. The extent of the coverage as reported from National Office, August, 1948, in "Excerpts from Canadian Press Clippings" gives some indication of the results of this endeavor. Her report also points out the desirability of coordinating the efforts of the Program and Arrangements Committees for the biennial meeting, and the Public Relations Committee.

Study Tours, I.C.N.

Details of the special course being planned in Norway in conjunction with the I.C.N. Conference in Stockholm are included under Notes from National Office in this issue. Too late to be incorporated with those *Notes*, information has been received at National Office of additional study periods which are being planned in the Northern Countries. The programs in Finland and Sweden will follow the I.C.N. Conference while that arranged in Denmark will be held, according to the demand, both before and after the Conference.

Applications to attend any of these courses should be made by individual nurses *with as little delay as possible.* These applications should be sent to the president of the national nurses' association of the country of your choice. The addresses are as follows:

Miss Marie Madsen, President
Danish Council of Nurses
Fensmarkgade 1
Copenhagen, Denmark

Miss A. van Bockhoven, President
National Council of Nurses of Finland

Hospital for Epidemic Diseases
Helsinki-Pasila, Finland

Miss Karin Elfverson
Acting President
Swedish Nurses' Association
Ostermalmsgatan 33
Stockholm, Sweden

The following brief summaries of the study tours offered will assist those going overseas to make their selection:

DENMARK

A program in Copenhagen and its environs, May 29-June 11, will include visits to such institutions as: Children's welfare work; public health nursing in industry; tuberculosis; care of the blind, deaf, crippled, chronically ill, mental cases, the aged; domiciliary nursing and midwifery; schools of nursing, etc. Arrangements will be made for tours to such points of interest as castles, a model farm, co-operative dairy, etc. Holiday guest cottages are available for those who apply early.

Following the Conference a ten-day program is being planned by the Arhus Branch of the Danish Council of Nurses. If there are enough participants, a lecture course will be arranged at the university in Arhus dealing with special conditions in Denmark, e.g.: social care, education, and the development of the co-operative enterprise, literature and language. Sightseeing trips will be arranged. Accommodation will be mainly at hospitals and in private homes so the cost will be kept at a minimum.

FINLAND

Beginning with a reception and sightseeing trips in Helsinki, the program includes an orientation in nursing and public health services. Group meetings will feature discussions on basic and post-graduate nursing education; public health nursing with emphasis on the introduction to field work; nursing service in hospitals; maternal health; child welfare; rehabilitation programs for cripples and war veterans. Visits to institutions will be planned. A midsummer-eve boat trip to the archipelago outside Helsinki will take place on June 23.

SWEDEN

Four three-day courses are planned to follow the Conference on June 17, 18 and 19, as follows:

Course 1: Historical course, with lectures and visits to the old buildings and museums of Stockholm, castles, and other things both in and near Stockholm.

Course 2: Social welfare and public health work, with lectures, demonstrations, and visits to different social institutions.

Course 3: Midwifery and maternity welfare, with lectures and visits to different institutions.

Course 4: A cultural course, including lectures about the geography of Sweden, history, literature, art, etc. Visits to museums, art galleries, the Royal Palace, etc.

The Swedish Nurses' Association is also planning to arrange for tours to various parts of their country. None of these trips is very expensive and would mean a wonderful holiday for any nurse.

Notes du Secrétariat de l'A.I.C.

LES INFIRMIÈRES ET LA SANTÉ DU MONDE

Dans son article de fond, le *Bulletin International des Infirmières* fait voir la valeur du travail des infirmières dans ces termes:

"Sans le service des infirmières un pays ne peut prospérer, puisque la survivance d'un pays et encore plus sa grandeur reposent sur sa capacité à protéger les faibles. La profession d'infirmière est synonyme de protection, de bons soins — soins à donner à ceux qui sont en santé, afin qu'ils demeurent en bonne santé, soins à donner aux malades, afin qu'ils recouvrent la santé."

Le Conseil International des Infirmières a été élu comme une société devant être en relation avec l'Organisation Internationale de Santé et ayant autorité de parler au nom des infirmières. Si cette reconnaissance a été accordée au C.I.I. on le doit à quelques infirmières douées d'une vision extraordinaire. Elles ont vu, il y a déjà cinquante ans, la nécessité pour les infirmières de s'organiser internationnellement.

Dans le *Canadian Nurse* du mois de janvier nous avons tracé le programme adopté pour l'O.I.S. La tuberculose et l'assistance

aux mères et aux enfants ont été jugées de première importance. Il ne faut pas perdre de vue le grand rôle important que joueront les infirmières dans la réalisation de ce programme. Même si les pays sont en guerre ou dévastés ou encore envahis, la contribution que l'infirmière apportera à tous, quelle que soit la race, la religion, sera très importante au point de vue santé internationale. La profession de l'infirmière repose sur des principes de charité, d'humanité, plutôt que sur des principes politiques. Elle est donc en meilleure position que quiconque pour travailler au maintien et au rétablissement de la santé de tout le monde, et son travail doit être considéré comme un facteur de première importance dans l'avancement du programme de santé mondiale.

Changements d'une Grande Importance

En Angleterre, il se fait une enquête sur le nursing et plusieurs changements ont déjà eu lieu que l'on a rapportés dans ces notes. Le gouvernement se propose de changer la constitution du General Nursing Council et de faire passer une loi lors de cette session, ayant pour but de donner une meilleure formation aux infirmières.

Le General Nursing Council (corps ayant les mêmes fonctions que nos associations provinciales, mais pour toute l'Angleterre et le pays de Galles) doit tenir un registre de toutes les infirmières d'Angleterre. Il a la responsabilité d'établir les normes servant à la formation de l'infirmière, nombre de lits, nombre d'institutrices, programme, etc., de faire passer les examens d'admission à l'exercice de la profession, et de déterminer ce qui constitue une infirmière professionelle. Voici les changements proposés par un comité chargé de l'enquête sur les infirmières:

1. Des centres ou unités de nursing seront établis pour remplacer les écoles d'infirmières actuelles. L'on propose de grouper plusieurs hôpitaux soignant différentes catégories de malades, afin d'offrir aux élèves un programme plus varié.

2. Qu'en plus des directrices du soin aux malades, qu'un principal soit en charge de cette unité du nursing.

3. Qu'il y ait relation entre ces unités du nursing et les services d'hygiène de la région par l'entremise des infirmières.

4. Que la division du nursing du Ministère de la Santé inspecte et approuve ces unités du nursing.

La dernière de ces propositions reçoit une vive opposition de la part des infirmières pour la raison suivante: Il semble que le corps professionel chargé de l'examen et de l'enregistrement des candidates doit logiquement être celui qui a la charge de faire l'inspection et de donner l'approbation de ces unités du nursing. Ces propositions ont certainement du bon, mais il serait imprudent d'adopter de tels changements, sans au préalable, en avoir fait l'essai et sans s'assurer que l'expérience a donné satisfaction. Au parlement, l'on a discuté comment les élèves de nos écoles d'infirmières peuvent être reconnues comme étudiantes au même titre que les autres (élèves en diététique, beaux-arts, sociologie, etc.) sans sacrifier leur expérience pratique. Le cours d'infirmière d'une durée de deux ans a été aussi discuté.

Les infirmières ont le droit de se faire entendre: leurs services sont trop précieux pour qu'on les ignore. L'on recommande donc aux infirmières de Grande-Bretagne d'être sur le qui-vive. Le même conseil ne pourrait-il pas être donné aux infirmières du Canada avec profit?

L'Union Fait la Force

La revue *American Journal of Nursing* rapporte que l'Association américaine des Hôpitaux a pris l'initiative d'organiser un comité conjoint, ayant pour but l'amélioration des soins donnés aux malades. Une meilleure entente entre médecins, infirmières, et administrateurs d'hôpitaux aura pour résultat d'améliorer les soins donnés aux malades. Le comité se compose de cinq représentants de l'Association américaine des Médecins, cinq de celle des infirmières, et cinq de l'Association des Hôpitaux (dans ce dernier groupe l'on compte des représentants des hôpitaux catholiques et protestants).

Congrès International des Infirmières

Durant la semaine précédant le congrès des cours seront donnés à Oslo, Norvège. Voici le programme:

Lundi, 6 juin — Inscription.

Mardi, 7 juin — Séance d'ouverture: La géographie et l'histoire de la Norvège. Conférence: La vie culturale en Norvège. Film: Les montagnes de la Norvège. Excursion à Frognersetere.

Mercredi, 8 juin — Conférence: Les services médicaux en Norvège. Film: "Un Danger Pour Tous." Excursion aux institutions médicales.

Jeudi, 9 juin — Conférence: Le nursing en Norvège. Conférence: Les infirmières hygiénistes en Norvège. Excursion aux écoles d'infirmières.

Vendredi, 10 juin — Conférence: La vaccination par le B.C.G. Excursion à Kringkastingshuset (la radio nationale). Excursion à Husfliden.

Samedi, 11 juin — Visite à un ancien moulin de papier. Départ pour Stockholm le soir.

Tous les cours seront donnés en anglais. Tous frais compris environ £15 ($65).

La Ligue de Santé du Canada

Comme représentante de l'Association des Infirmières du Canada, Mlle H. McArthur assista à la réunion annuelle de La Ligue de Santé du Canada. L'on étudia particulièrement le besoin de co-ordination entre les associations de bienfaisance.

D'autres questions intéressantes furent aussi discutées — la pasteurisation du lait, l'arthrite, la nutrition, l'hygiène publique, et la santé dans l'industrie.

"Le dernier sujet à l'étude m'a vivement impressionné," dit-elle. "Le travail fait par la Ligue dans l'industrie est considérable. Plusieurs centaines d'infirmières employées dans les industries assistaient à la réunion. Comment la Ligue a-t-elle réussi à soulever un si grand intérêt? Très probablement que les employeurs ont eu leur mot à dire. Néanmoins, cette réunion, plus que celles des infirmières du Canada ou de l'Association canadienne de l'Hygiène Publique, semble avoir aidé les infirmières à mieux se comprendre et à les intéresser."

Le Comité de la Santé dans l'industrie publie un journal mensuel, *Industrial Health*. Les articles variés sont de nature à intéresser les différents groupes dans l'industrie — les ouvriers, le service médical, l'administration, les chargés du bien-être des employés, etc. Le comité a affirmé son désir de travailler en collaboration avec les autorités fédérales et provinciales aussi bien qu'avec les associations professionnelles ou ouvrières.

Relations Extérieures

Le rapport du Comité National des Relations Extérieures, A.I.C., fut présenté. Le travail qu'elle a accompli est remarquable, des nouvelles concernant les infirmières paraissant dans les journaux du Canada.

Le Comité des Relations Extérieures croit qu'il est nécessaire de renseigner les médecins et les administrateurs d'hôpitaux sur l'école de démonstration de Windsor. L'on a demandé au secrétaire de l'Association Médicale du Canada et a celui du Conseil canadien des Hôpitaux une entrevue. A date, l'un des secrétaires a été rencontré et il est en faveur de la publication de temps à autre d'articles sur la profession d'infirmière dans le journal de l'Association Médicale. Des articles semblables devraient être présentés dans ses revues ou journaux.

Advanced Practical Obstetrics

The following six students have completed the four-week course in Advanced Practical Obstetrics for District Nurses given at the school of nursing, University of Alberta: Laura Attrux, Maxine Bow, Enid Doyle, May Sandercock, Mrs. Catherine Somerville, and Winnifred Tredaway. Miss Attrux, Mrs. Somerville, and Miss Doyle are returning to the provincial district nursing staff. Miss Bow and Miss Tredaway are members of the staff of the Victorian Order of Nurses. Miss Sandercock plans to do small hospital work.

The students observed about fifty deliveries during the first part of the course, and delivered twenty or more cases under supervision during the period of practical work. Each student spent two weeks in obstetrical clinics, receiving instruction and experience in ante-partum care and examinations, and in post-partum care. Further experience and instruction in abdominal palpation was given in the hospitals.

As free hospitalization is provided for maternity cases in the province of Alberta, the district nurses try to send all patients to hospital for confinement. However, due to distances and difficult travelling conditions at certain times of the year, they are still called upon to deliver cases in the home. They also give most of the ante-partum care even when the patient plans to be confined in hospital. Stress is laid upon teaching the student to recognize the abnormal, so that extra precautions may be taken to have the patient go to the hospital before the onset of labor.

Student Nurses

Coronary Thrombosis

CATHERINE M. RICHARD

MR. F WAS ADMITTED by stretcher on June 4 at 3:20 p.m. At 2:00 p.m. that afternoon he had been seized with a severe pain in the cardiac region which radiated down his left arm. It was the first pain of this kind he had ever had. It came on suddenly while he was walking down the street. He was able to make his way to a nearby drug store and lie down. A doctor was summoned. Mr. F was then given morphine sulphate gr. ½ with atropine gr. 1/150 hypodermically, and nitroglycerin gr. 1/100 (H) sublingually. The doctor's diagnosis was coronary involvement.

Mr. F was fifty-two years old. He was married and father of two sons. He had served overseas in the Canadian army in World Wars I and II holding very responsible positions. He was a tall, heavily-built man, pleasant and healthy in appearance. His actions were very quick, forceful and vigorous. He had a great interest in his family and social life. He smoked a great deal and indulged in alcohol.

His pulse on admission was rapid, irregular, and faint (109 beats per minute). His breathing was shallow and rapid (resp. 28). He was given pantopon gr. ⅓ every three hours for pain and restlessness. At 6:00 p.m. one tablet of sodium nitrate gr. 1 was given to relieve pain by relaxing the spasm of the coronary artery.

The first three days morphine sulphate gr. ¼ was given hypodermically on each severe attack, as morphine is the only drug that can relieve this pain. The second night he was very much cyanosed with pain in his cardiac region. He was given oxygen 7 litres per minute for ten minutes to relieve asphyxia. Most of the attacks during the first two weeks occurred at night. He slept very little and was restless. Sodium amytal was given as the sedative; after a month phenobarbital gr. ½ was ordered to be given three times a day.

The eighth day, tincture of digitalis, minims 10 three times a day, was ordered. Digitalis makes the heart beat stronger, thus causing the pulse beat to be slower and stronger. Mr. F's pulse and respirations the first two weeks averaged 90-102 per minute and respirations 24-26. By June 30 the pulse rate was 80-90 with respirations 20-22. His temperature remained around 100° till June 9, then ranged around normal. His blood pressure was 108/50, which was actually very low due to the state of shock. On June 9 an electrocardiogram was done and a diagnosis of coronary thrombosis was made.

Mr. F's laboratory reports were as follows:

Urinalysis: June 5 — s.g. 1.035; June 12 — s.g. 1.010. Normal — 1.010 to 1.030.

Blood morphology: The first report showed the red blood cell count as 5,140,000, the white blood count as 25,100, and the hemoglobin 92%. On August 30, the report showed the R.B.C. 4,830,000, W.B.C. 7,600, and the hemoglobin 97%. An increase in the temperature and leukocytosis result from the absorption of necrotic material from the part shut off by the obstruction.

The *sedimentation rate* on July 23 was 19.5 for 30 min., 22.0 for 60 min. It had dropped to 3.0 and 9.0 by August 30. Normal sedimentation rate is 2 mm. per minute. The rate goes up when there is an increase in the leukocytes.

Miss Richard is in training in the school of nursing of the Victoria Public Hospital, Fredericton, N.B.

There is a great danger of the heart rupturing during the two weeks following the attack. We kept Mr. F in a semi-sitting position supported well by pillows. He felt comfortable in this position. It was stressed to him that he should remain perfectly quiet, and rest and sleep, not moving to do anything for himself. Mr. F was an intelligent man and co-operated very well. The room had two large windows and was thus kept freely ventilated. It was situated at the end of the corridor where little noise could be heard. Large signs were placed on the door — "No visitors allowed" and "Quiet, please." We gave him an alcohol rub frequently to prevent bed sores which could have been formed easily because of poor circulation when he was lying so quietly. We turned, lifted, and fed him. So he would not have to strain to make his bowels move he was given a mild laxative each evening. If this did not take effect fairly quickly, a small soap-suds enema was given. His diet the first two weeks was mainly liquids. An intake and output sheet was kept.

Mr. F was quite restless at times and was very much depressed, took no interest in his surroundings and was very irritable. He worried about his family, his work, and his condition. He knew how serious his condition was but always looked forward to getting well. We tried to keep him as cheerful as we could.

Before giving him his digitalis we took his pulse to make certain it was not below 60. A low pulse, vomiting, intestinal upset are signs of overdosage. The digitalis was discontinued on July 5.

Towards the latter part of the third week Mr. F's condition improved. As this improvement increased he became more difficult to manage. He had to be reminded constantly of his condition and the dangers of overexerting himself. He slept quite well at night; then in the morning after his bath he slept till nearly noon. His diet was increased to soft with small servings. We brought him the daily papers and magazines. He read for a little while in the afternoon, then he would sleep again. At the end of six weeks he was able to get up in an arm-chair for fifteen minutes each morning. We watched him closely to see that he did not feel faint or tired.

Mr. F. later was on ordinary diet and had a good appetite. During his convalescence, in our conversations with him, we explained how necessary it would be for him to rest and not be too active in his exercise, pointing out that too much strain on his heart would bring on another attack. He must avoid infectious diseases, lest the heart muscle, which was already weak, be affected. He must avoid over-eating and emotional upsets.

Mr. F. was discharged from the hospital on September 8. He resumed his office work and is now living a normal, healthful life. He sees his doctor for examinations regularly and is very careful to avoid overexertion. Through medicine and good nursing care Mr. F, once so near death, should be able, by taking care of himself, to live many more years.

Use of Digitalis

Every heart is endowed with the ability to work at a given mechanical efficiency which cannot be increased by digitalis. However, when organic heart disease reduces this inherent mechanical efficiency, digitalis tends to restore it toward normal levels. It seems that digitalis is definitely indicated for organically diseased and enlarged hearts which appear clinically compensated, when the circulation time is greater than 16 seconds.

— E. W. Erickson, M.D.

Value of BCG

The Expert Committee of the World Health Organization emphasized the value of BCG as the only practical way known so far to build up resistance against tuberculosis among groups of the population most exposed to this infection. Referring to the part played by WHO in the "International Tuberculosis Campaign" (UNICEF and the Scandinavian Red Cross) in its mass vaccination program, the experts recommend that WHO assist in the establishment of BCG laboratories throughout the world.

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Book Reviews

Psychiatry in Nursing, by Raymond Headlee, M.D., and Ronnie Wells Corey, R.N. 308 pages. Published by Rinehart & Co. Inc., 232 Madison Ave., New York City 16. 1948. Price (in U.S.A.) $3.50.

Reviewed by Flora George, Director of Nursing, Verdun Protestant Hospital, Montreal.

This book is divided into three parts, i.e.: Part I — Normal Variations in Human Behavior; Part II — The Varieties of Mental Illness; Part III — The Practice of Psychiatric Nursing.

Part I, as stated, deals with such topics as the meaning of the mind, normalcy and mechanisms of thought, sexual adjustment, pain and sleep. As one presumes that it is intended as an introduction or preparation to Part II, one could wish that further material had been added. As an introduction to psychiatry, Part I is rather limited, leaving the reader in some doubt as to the actual purpose of this section of the book. Part II. The varieties of mental illness are treated in some detail and are well covered. Of particular interest and a welcome addition to this type of text are the chapters on psychoneuroses and amoral behavior. While each disease is treated briefly, it is concise and clear. Part III. The practice of psychiatric nursing is described in principle and is applicable to any situation.

Throughout the book, behavior is stressed with the problems of the individual patient; only the general outline of psychiatric nursing is given, but this is satisfactory and does not detract from its value.

A new departure is the appendices, with study hints, case studies, and reference reading. The latter is particularly well organized, covering a broad and general field of reading under headings, which make it easy for the student to follow in more detail the topics of discussion in the book.

In general, one believes that the authors have tried to follow the behavior patterns as related to the patient as a person, rather than classifying the disease with symptoms; this is to be commended.

This book would well serve as a text in the basic course of nursing in psychiatry, with the reference text to give the nurse a greater understanding of her patient's behavior difficulties and of her own personality problems.

Posture and Nursing, by Jessie L. Stevenson, R.N., P.T. 96 pages. Published and distributed by the Joint Orthopedic Nursing Advisory Service (N.O.P.H.N. and N.L.N.E.), 1790 Broadway, New York City 19. 2nd Ed. (revised) 1948. Illustrated. Price (in U.S.A.) 50 cents.

First published in 1942, this little handbook has been completely re-written in accord with suggestions made by those who had made the most use of the first volume. A very liberal supply of illustrations provides graphic opportunities for the learner to adapt her own posture to the suggested patterns.

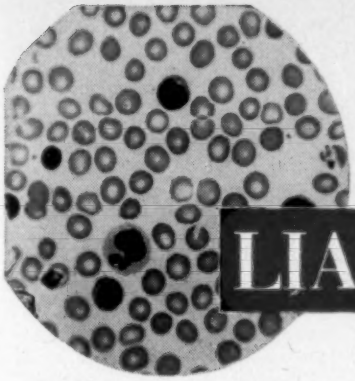
One has only to observe the round shoulders, the tense tiredness, the positions of strain when working, to realize how definitely nurses need both advice and practice to achieve good body mechanics. Few schools of nursing are equipped with a gymnasium or provide physical education during the whole three years of the student's training. Yet, since there is a right way and a wrong way to stand, walk, bend, lift, or pull, it is sensible to use the method that results in least effort and strain. If every head nurse had a copy of this manual on her desk, with which she was sufficiently familiar to enable her to refer her ward staff to the correct methods whenever gross errors occur, she could help the students to smarten up their physical appearance, the girls would be less weary, and the general atmosphere would be relieved of much strain. Who knows? Possibly the patients would note the difference and be inspired to improve their own posture.

The Premature Baby, by V. Mary Crosse, M.D. (London). 156 pages. Published by Doubleday Publishers, 105 Bond St., Toronto 2. 1st Ed. 1946 (reprint). Illustrated. Price $3.50.

Reviewed by Caroline V. Barrett, Supervisor, Royal Victoria Montreal Maternity Hospital.

The author is eminently qualified to write this book. For fourteen years, Dr. Crosse has been studying measures to reduce mortality among premature infants. As she points out in her introduction: "Because of the declining population and low birth-rate, more attention is now being paid to the prevention of early loss of life—of which the greatest single cause is prematurity."

The subject matter is well presented and



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well illustrated. Her treatment of the care of the premature infant is very comprehensive. She emphasizes the need for highly specialized personnel in order to obtain the best results

In her chapter on Preparation for the Discharge of Baby, she stresses the importance of home inspection and education of the mother in the care of her infant, as well as the necessity for attending child health clinics—in short, correlation of hospital and community nursing.

As this book was written in 1946, no doubt more modern methods of oxygen administration are now being carried out in the premature ward which the author uses as an example.

This book would be an asset to any pediatric or obstetric library.

Hospital Trends and Developments (1940-46), edited by Arthur C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. 819 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1948. Price (in U.S.A.) $5.50.

Those who are familiar with "The Hospital in Modern Society" will welcome this second volume which picks up the links in the numerous lines of hospital and health developments which have been expressed in printed form since the earlier volume was published. These excerpts cover the years 1940-46. Few nurses have access to the impressive array of periodicals from which the selections were made. They will, therefore, welcome this compilation with interest. Nearly 150 magazine articles have been included. It would be an overpowering dose to attempt to read right through this volume but, as a reference on virtually every aspect of hospital activity, it is of pre-eminent value.

Since nursing is an integral part of many aspects of hospital activity, it is natural that one chapter should be devoted to nursing education and nursing service. However, only eight articles are included here, two of which deal specifically with the use of nursing assistants. Many dominant nursing problems are omitted entirely.

Each chapter is well documented with additional topics for reference reading by competent authors.

Whenever you are perfectly clear about anything you may be pretty sure of having left out some important factor.

—A. N. WHITEHEAD

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A to Z

Aglossia:	Congenital absence of the tongue.
Blennoid:	Resembling mucus.
Chlorephidrosis:	Green perspiration.
Dentibuccal:	Pertaining to the cheek and the teeth.
Epluchage:	Wound excision; the cutting away of the contused and contaminated tissues of the wound.
Folie:	Psychosis.
Gnosia:	The faculty of perceiving and recognizing.
Holotonia:	Muscular spasm of the whole body.
Isolophobia:	Abnormal dread of being alone.
Jacaranda:	Leaves of South American tree; used in syphilis.
Kenotoxin:	A toxin produced by muscular contraction.
Loculus:	A small space or cavity.
Methomania:	Insanity from alcoholic drinks.
Notancephalia:	Absence of back of skull.
Odynacusis:	Painful hearing.
Parodontopathy:	Any disease of the tissues around the teeth.
Quigila:	An infectious disease resembling leprosy, occurring in Brazil.
Rodagen:	A preparation of the milk of goats deprived of their thyroids.
Sarcology:	The science of the soft tissues of the body.
Telesthesia:	Telepathy; perception at a distance.
Urocrisia:	Diagnosis by observing the urine.
Virucidal:	Inhibiting the action of a virus.
Wagstaffe's fracture:	Separation of the internal malleolus.
Xerosis:	Abnormal dryness, as of the eye or skin.
Yucca:	Genus of plants; the wood of some species is used for surgeons' splints.
Zestocausis:	Therapeutic application of superheated steam.

It is dainty to be sick if you have leisure and convenience for it.—EMERSON

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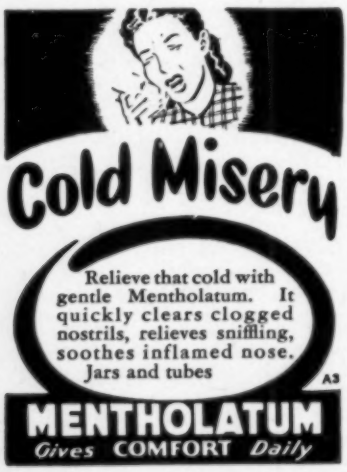
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— *New England Journal of Medicine*

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1. Standard No. 200 Solvent (obtainable at Standard Oil stations).
2. Union Oil Company No. 1 Solvent.
3. Any petroleum naphtha with a boiling range of 70° C. to 130° C.

Persons using any fat solvents are reminded that they should be provided with the proper gloves made of one of the synthetic rubber materials. Care should be taken to avoid flames as all of these materials are highly inflammable.

— *California's Health*

Nursing Sisters' Association

The following officers will serve on the national executive for the coming biennium: President, Lillian MacMillan, 3338 W. 18th Ave., Vancouver; vice-presidents, A. L. Young, Mmes G. H. Stead, C. A. Young; secretary-treasurer, Catherine Golightly, Shaughnessy Hospital, Vancouver; president, Vancouver Unit, Mrs. C. A. Scott, 1974 Matthews Ave.; councillors, M. Burton, Mrs. A. W. Hunter.

The N.S.A.C. sent the following message to H.R.H. Princess Elizabeth on the birth of her son: "Congratulations and best wishes to you and the Duke of Edinburgh on the birth of your son, from the Nursing Sisters' Association of Canada." The following reply was received: "We wish to thank you for your message of congratulations and good wishes. Elizabeth and Philip."

The ebb and flow of nurses getting back into "Civvy Street" has become less marked, and they are gradually settling into positions they intend to keep. It is hoped they will join and support the unit in their district. With so

many experiences that have been shared, companionship of a rare quality is to be found in these groups.

The *Edmonton Unit* had seven regular meetings during the past year with an average attendance of nineteen. The money received from the January rummage sale was put into the general fund. Comforts were provided for veterans in hospital. Members helped in the canvass for the blind and also with the Red Cross annual blood donors drive. In April the unit was presented with an oak gavel made from wood from the door of a bombed cathedral in France. Two members represented the unit at a tea given in honor of Miss Bennett, a nursing sister from England. A wreath was laid at the cenotaph on Armistice Day. A decision was made at the November meeting to send Christmas cards to all veteran patients in hospital instead of buying presents.

More interest is being shown by the members of the *Hamilton Unit* this year. Each year an effort is made to raise money to provide some working capital. This time each member and non-member was given a small "mite box" for the purpose of collecting odd change. The returns are not all in but the results to date have proved worthwhile. Until last year, the group was forced to meet here, there, and everywhere. Now, thanks to the committee formed for that purpose, the Air Force Officers Mess of 424 Fighter Squadron is the scene of the monthly get-togethers. Fifty members were present at the annual dinner which took the form of a buffet supper held in November.

The members of *Kingston Unit* took part in the memorial services on Armistice Day. In the evening a banquet and the first fall meeting were held, when forty-one members were present, including sisters from W.W. I and II. So the sisters could get to know each other better, each member was asked to tell a short story of her travels and experiences in the services. It proved to be a wonderful idea. When notes were compared, many names of friends were revealed. It was discovered that girls were present who had served in Sicily, North Africa, Italy, as well as other centres in Europe. Also among those present were the less fortunates who never left Canada!

During the past year, the *Montreal Unit* held one special, three executive, and three general meetings. At the former, Madeline Taylor spoke on her experiences with UNRRA. A bridge party was held at Queen Mary

Every year more Canadian hospitals are using the two excellent textbooks listed below. Both contain the latest advances in nursing and both are arranged for the greatest convenience of instructors and students.

SURGICAL NURSING

By Robert K. Felter, Frances West, and Lydia M. Zetzsche. This new, radically revised edition contains new units in Orthopedics, and Surgery of the Eye, Ear, Nose and Throat. 308 illustrations, over 700 pages, fifth edition, 1948. $4.25.

MEDICAL NURSING

By Edgar Hull and Cecilia M. Perrodin. Covers every phase of medical nursing. 641 pages, 152 illustrations, third edition, 1946. $4.00.

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Veterans Hospital in May from which a considerable sum was realized. Due to difficulties of transportation, the nurses at St. Hyacinthe D.V.A. Hospital were unable to attend, but instead held a bridge of their own, forwarding their returns to the unit. Miss Henderson, matron, Queen Mary Veterans Hospital, placed the wreath at the cenotaph on Armistice Day. Approximately 128 members attended the dinner held in the evening when Mr. R. A. Speirs, headmaster of Selwyn House, was guest speaker. He gave an interesting talk on Scottish literary men of genius.

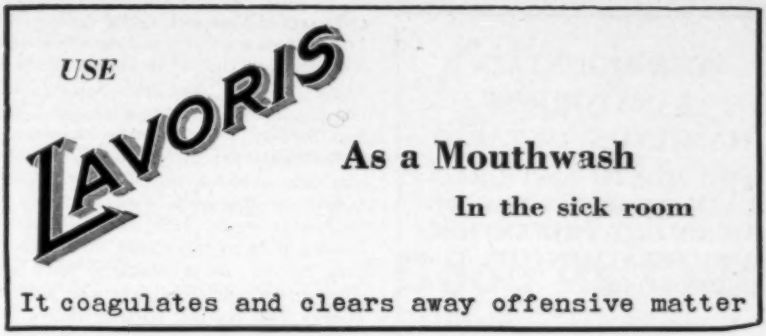
The president, Miss Kennedy-Reid, attended the biennial meeting, as a delegate from the unit, held at Sackville.

The *Vancouver Unit*, with Mrs. C. Arthur Scott as president, has been very active with a membership of 150. Mrs. Scott recently loaned her home for a cocktail party, to enable the nurses of W.W. I and II to meet each other. The chatter of voices would indicate that it had accomplished the desired result, and many new members joined the unit. During the summer a most enjoyable picnic was held at the home of Mrs. Sheppard on Lulu Island. The Armistice dinner was successful with an excellent attendance. The sisters joined in the Armistice service at the cenotaph and Mrs. Scott laid the wreath. Another program, "Parade of Fashion," sponsored by Lever Bros., was thoroughly enjoyed and added $50 to the Sick Fund.

Alberta

The following are staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Blanche Emerson*, who joined the staff last September as acting assistant director, now acting director; *Mary MacDonald* (Misericordia Hospital, Edmonton, and University of Toronto public health course) to Pembina health unit, Barrhead. (Miss MacDonald served approximately four years with the R.C.A.M.C., two and a half years of which was in England and on the Continent.) *Camilla Hudson* to Spirit River health unit; *Marjorie Mitchell* (Galt Hospital, Lethbridge) to Blueberry Mountain; *Dulcia Williams* (Moose Jaw General Hospital) to Grassland; *Carol Gaunt* (Royal Alexandra Hospital, Edmonton) to Tulliby Lake; *Mrs. K. Coutts* (Winnipeg General Hospital) to Youngstown district.



Transfers: *Frances Smith* from Grassland to New Brigden; *Nina Renwick* from Blueberry Mountain to Bonanza; *Margaret Wyld* from Smith to Kinuso; *Ann Nordtorp* from Tulliby Lake to Smith.

Leaves of Absence: *Marguerite Fitzsimmons*, formerly at Youngstown, is enrolled at the University of Toronto for work in advanced public health nursing (supervision).

Resignations: *M. A. (Evans) Martin*, acting director since last September. *Katherine Brandon*, formerly at Hilda, is now with the McLeod-Pincher Creek health unit, Granum.

M.L.I.C. Nursing Service

The following are staff changes in the nursing service, Metropolitan Life Insurance Company:

Julie Lefrançois (St. Sacrement Hospital, Quebec), *Bernadette Tessier* (Ste. Justine Hospital, Montreal) and *Brigitte Beaudet* (Notre Dame Hospital, Montreal) have been appointed to the Montreal staff. *Rose Theberge* (l'Enfant Jésus Hospital, Quebec), of the Montreal staff, has resigned from the Company's service.

Ontario

The following are staff changes in the Division of Public Health Nursing, Ontario Department of Health:

Appointments: *Isabel (Husher) Lutton* (B.Sc. degree, University of Western Ontario certificate course), formerly on nursing staff, Secondary Schools, London, to Peel County health unit; *Frances Simpson* (Royal Victoria Hospital, Montreal, and University of Toronto cert. course), North York board of health; *Ruth Fair* (Toronto General Hospital and U. of T. cert. course), York Township board of health.

Resignations: *Julienne Gagner* (St. Joseph's Hospital, Chatham, and U. of W.O. cert. course) from Windsor board of health.

Victorian Order of Nurses

The following are staff changes with the Victorian Order of Nurses for Canada:

Appointments: *Mary E. Ashley* (University of Toronto public health course), *Lenore Mather* (U. of T. p.h.n.), *Mrs. Catherine Mowbray* (U. of T. p.h.n.), *Elizabeth M. Naylor* (U. of T. p.h.n.), *Jean D. Smillie* (U. of T. p.h.n.), *Edna Stephenson* (U. of T. p.h.n.), *Barbara F. Wisener* (U. of T. p.h.n.) *Lillian M. Yamazaki* (U. of T. p.h.n.), *Nellie Siemens*, to Toronto; *Mrs. Beverly Colewell* (University of Western Ontario public health course), Kingston; *Jane Macintyre* (McGill University public health course), *Evelyn Shiels* (McG. U. p.h.n.), Ottawa; *Eva P. Spector* (McG. U. p.h.n.), *Catherine Jefferson, Isabel H. Kemp, Anna M. Knecht, Mary L. Looby, Joan Piddington, Marjorie J. Rideout, Mrs. Lucy Weeks, Kathleen Wortman*, to Montreal; *Anne Steem* and *Luba Gold*, Vancouver; *Phyllis Fraser* (University of Alberta public health course), nurse in charge at Sackville, N.B.; *Jean Allen*, Winnipeg; *Mary J. Prang*, York; *Wilma Armstrong*, Peterborough.

Re-appointments: *Hattie Empey* (University of British Columbia), Hamilton; *Lorraine Miller* (McG. U. p.h.n.), Vancouver; *Margaret Hollenbeck* (McG. U. p.h.n.), nurse in charge at North Vancouver; *Christina Muise* (McG. U. p.h.n.), Halifax.

Transfers: *Mary DeGiacoma* from Port Arthur to Winnipeg; *Alice Julien* from Lincoln to Hamilton; *Audrey Price* from North Vancouver to Burnaby.

THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

TWO-MONTH POST-GRADUATE COURSE IN THE IMMUNOLOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS.

This course is especially valuable to those contemplating Public Health, Industrial, or Tuberculosis Nursing.

For further information apply to:

Superintendent of Nurses, Mountain Sanatorium, Hamilton, Ontario.

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PREVENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary—$104.50 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

Leaves of Absence: *Cicely Helliar* from Toronto to work a year in England; *Doris J. Knechtel* from Toronto to take public health course; *Erie V. Lloyd* from Saint John to take public health course; *Marguerite Topper* from Toronto to take public health course.

Resignations: *Evelyn Bond* from Chatham, Ont., to be married; *Margery L. Jackson* to take up other work, *Ruth M. MacMillan* for further study, *Mrs. Noma Pollak* and *Dorothy Wick* to take public health course, from Toronto; *Olwin MacInnes* from Sackville to take public health course; *Catherine Murray* from Halifax; *Caroline Farina* from Victoria for further study; *Elizabeth Aylward* (retired) from Campbellton; *Mary R. Fenton* from Trenton for further study; *Maud Haslam* to take public health course and *Mrs. Grace Wright* from Hamilton; *Margaret Perfect* from Winnipeg to take public health course; *Kezia Wilson* from Truro to be married; *Mrs. Norah Berry* from Ottawa; *Vera O'Dell* from Calgary to take up other work; *Blanche Reid* from Galt to be married.

News Notes

BRITISH COLUMBIA

Vancouver General Hospital:

The December alumnae association meeting took the form of a social evening when the probationers entertained with Christmas carols. Members of the Vancouver Little Theatre Society followed with an amusing skit. Mrs. R. Telford concluded the program with her presentation of a monologue entitled "The Littlest Angel." Prior to the social activities, plans for the celebration in May of the 50th anniversary of the founding of the V.G.H. School of Nursing were discussed.

MANITOBA

BRANDON:

C. Wedderburn was in the chair at a recent meeting of the Association of Graduate Nurses when Mrs. M. Schonberg, public health nurse, was the guest speaker. Her topic was "The Importance and Need of Specially Trained Nurses for the Outposts of Canada." B. Taylor introduced the speaker who was thanked on behalf of the group by Mrs. E. Mills.

General Hospital:

Dr. G. W. J. Fiddes, who leaves shortly to become a medical missionary, was honored

at a reception when, on behalf of the staff, he was presented with a doctor's watch, suitably engraved. A purse of money was also presented to him by the medical staff.

Recent graduates of the school of nursing, who have attained their R.N. standing, were entertained at a tea given by the graduates on the hospital staff. Barbara Taylor was hostess.

NEW BRUNSWICK

SAINT JOHN:

General Hospital:

A delightful party was recently held in honor of Margaret Murdoch, who has retired after thirty-two years' service on the staff, twenty-seven of which she was superintendent of nurses. Lyla Belding presided at the tea table while Jean Malzard, chief dietitian, and her staff served refreshments, assisted by the staff supervisors. On behalf of the staff graduates, Louise Peters, assistant superintendent of nurses, presented a wing chair to Miss Murdoch as a parting gift. Dr. E. W. Lunney, newly-elected president of the medical board, presented a bouquet to Miss Murdoch and a cheque from the members of the medical staff. Mr. R. H. Gale, hospital superintendent, read a letter of appreciation for her long and faithful service from the board of commissioners. She was also the recipient of a mahogany table from the private duty nurses.

The annual student Christmas party was also a farewell party for Miss Murdoch. An entertaining program was presented, including a vocal solo by Miss Templeton, piano solo by Miss Palmer, and the distribution of gifts. The mistress of ceremonies, Lorna Wood, on behalf of the student body, presented Miss Murdoch with a tri-light lamp and expressed heart-felt appreciation for her ever-present guidance. As a Christmas gift, the Student Council presented Miss Murdoch with a cup and saucer.

Misses Murdoch and Peters received the guests at the dance held during the holiday season by the student nurses.

The private duty nurses entertained informally in honor of Phyllis Fraser on the eve of her departure for Vancouver. On behalf of those present, Mary Scott presented Miss Fraser with a compact. The supervisors and general duty nurses of the 4th and 5th floors entertained informally in honor of Eunice Rogers and Eunice Bolsh, of Edmonton, prior to their departure for Cincinnati. Catherine Vaughan is taking a post-graduate course in obstetrics at the Royal Victoria Hospital, Montreal.

ST. STEPHEN:

The home of the president, C. Dowling, was the scene of a recent meeting of St. Stephen Chapter. The report of the executive meeting of the provincial association was read by M. Dunbar. This meeting was called to discuss what can be done to further the interests of the nursing profession in the use of the sum that is coming to the province

Good As Gold

What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

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Vapo-Cresolene

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Whooping Cough in 80% of cases
Bronchial Asthma in 76% of cases
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Bronchitis in .... 83% of cases

Vapo-Cresolene reduces nasal congestion, soothes and relieves the throat irritation that causes coughing.

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through the Federal Health Grants. F. Cunningham was appointed to take charge of the box of clothing and food for a retired sick nurse. A ticket was drawn on a blanket, the proceeds from the project to go towards the Sick Nurses Benefit Fund. It was reported that a wreath was placed at the cenotaph on Remembrance Day.

ONTARIO

District 6

PETERBOROUGH:

The nurses' residences of the Civic and St. Joseph's hospitals were the scene of the three lectures of the recent refresher course for graduate nurses. There was an average attendance of 110 at each session.

The program was as follows: *Lecture 1* — Prostatitis: Diagnosis and treatment —Newer methods of surgery, Dr. R. K. Magee. Nursing care following prostatectomy — demonstrations: (a) Tidal irrigation, Miss Snider, St. J. H.; (b) continuous irrigation (dressing—intravenous infusion), Misses Robson and Nesbitt, C. H. *Lecture 2* — Fractures: Newer methods of treatment — Indications for use of Stryker frame, Dr. Donald Whyte. Nursing care of patient on Stryker and Bradford frame (demonstration), M. Pickens, nursing arts instructor, C. H., and E. Fenwick, science instructor, C. H. *Lecture 3* — Newer methods of anesthesia, Dr. Wishart. Contribution made by nurse to patient (pre- and post-operatively), Miss Barnett, St. J. H. Demonstration of oxygen equipment and newer drugs used, Sr. St. Agnes, St. J. H.

CHARGE NURSE
for
Psychopathic Ward, General Hospital, Regina.

Salary: $200-$245 per month
(including Cost of Living Bonus)

Duties.—Under direction from the Chief Psychiatrist: To supervise nursing services, patient care and such special treatment techniques as physio-psycho-recreational and occupational therapy on both male and female wards; to assign ward staff, to develop programs of instruction and orientation for new personnel and to prepare service reports on them. To supervise and participate in an in-service program for training psychiatric nursing personnel and undergraduate nursing affiliates through lectures and demonstrations and to prepare progress reports on all students.

Requirements: R.N. with considerable experience as a Psychiatric Nurse, post-graduate courses in administration and ability to lecture at a university centre in the field of specialization.

For application forms and further information apply to:

Public Service Commission,
1730 Scarth Street, Regina, Sask.

Closing date for receipt of applications: *March 15, 1949.*

District 8

OTTAWA:

The Assembly Hall of the University of Ottawa School of Nursing took on a cosmopolitan appearance one evening when the public health and nursing education students arranged a historical nursing pageant for the enjoyment of the faculty and the alumnae.

As the guests arrived they were taken aback somewhat to see Clara Barton in animated conversation with a white-coiffed Sister of Charity and a pagan nurse, of some pre-Christian century, dressed in rich Oriental robes, while in the centre of the Hall might be seen Mary Agnes Snively with Jeanne Mance, and an inimitable "Sairey Gamp" discussing an interesting display of pictures of the outstanding women and men in nursing from the days of ancient Egypt down to the contemporary dean of nursing education.

Nurses participating in this colorful event were: E. Marc as a pre-Christian nurse; A. O'Leary as Fabiola; B. McCoy as a Belgian Beguine; K. Bayley as Sairey Gamp; J. Stock as Betsy Prig; Mrs. M. Pacio as a Sister of Charity; Mrs. M. MacPherson as Freiderike Fliedner; M. Kinsella as Florence Nightingale; G. Perrier as Jeanne Mance; L. Gendron as Clara Barton; L. Miocich as Mary Agnes Snively.

Each student gave a synopsis of the nursing period which she represented. The continuity of events through the centuries was maintained by Rev. Sr. Mooney, Cornwall, in a running commentary, augmented by a large graph depicting the divisions of nursing history into four large segments of time: Pre-Christian era, from the very early days to the time of Christ; Christian era, from the time of Christ to 1500 A.D.; period of degradation, from 1500 A.D. to 1860 A.D.; scientific, philanthropic era, from 1860 A.D. to the present day.

Following this enjoyable entertainment, the students served lunch and finished the evening with singing and "shop-talk."

Positions Vacant

WANTED

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REGISTRAR

for

Alberta Association of Registered Nurses

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State professional and academic qualifications, also age and salary expected.

Submit applications to:

Miss Blanche A. Emerson, President, A.A.R.N., 23 Réné Lemarchand Mansions, Edmonton, Alberta.

Director of Public Health Nurses for Health Dept., City of Ottawa. Apply, stating age, complete details of education with dates of graduation, also details of working experience, to M.O.H., Health Dept., City of Ottawa, Ont.

Head Nurse to take charge of 20-bed ward in new wing of 250-bed hospital. Also **Second Asst. to Head Nurse** for 80-bed Male Ward. Apply for further information to Supt. of Nurses, General Hospital, Port Arthur, Ont.

Instructor in Principles & Practice of Nursing to teach & supervise the Nursing Arts. **Lecturer in Public Health Nursing** to assist in administration & teaching of post-graduate courses in public health nursing. **Science Instructor** to teach the basic sciences in undergraduate program (new appointment). Apply, stating qualifications, to Director, School of Nursing, University of Alberta, Edmonton.

Public Health Nurse for Villages of Richmond Hill & Woodbridge & Township of Vaughan (about 15 miles north of Toronto). Schools major portion of work. Liberal salary according to experience. Applicants advise if car is to be provided. Apply, stating age, experience, nursing training, etc., J. M. McDonald, Municipal Offices, Maple, Ont.

General Duty Nurses for modern, well-equipped hospital of 110-beds. Salary: $115 plus maintenance. Annual increase of $60 for 3 yrs. Accumulative sick time. Medical & hospital plans available. 1 mo. holiday after 1 yr. service. 8-hr. day, 6-day wk. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Nurses urgently needed for new, small hospital in San Joaquin Valley, Calif. Hospital is well equipped & town offers all the advantages & pleasantness of life in a small community within easy travel distance of Oakland & San Francisco. 40-hr. wk. Minimum starting salary: $220. **Qualified Supervisors & Nurses** will have first choice & excellent chances to be considered by Administrator-Consultant for advanced positions in 3 other Calif. hospitals upon completion of construction in Fall, 1949. Write Administrator, Community Memorial Hospital, Tracy, California.

Graduate Nurses for General Duty in Operating-Room, Obstetrical Dept., Medical & Surgical Floors. Apply Director of Nurses, Bismark Hospital, 6th & Thayer, Bismark, North Dakota.

General Duty Nurses (2) for 20-bed hospital in good Alberta town. Comfortable modern nurses' home. Salary: $140 per mo., increased to $145 per mo. after 6 mos. service & to $150 per mo. after 1 yr. service, plus full maintenance. Apply Supt., Municipal Hospital, Coronation, Alta.

Nurse for 25-bed United Church Mission hospital on British Columbia coast. Salary: $120 per mo. & maintenance to start. 5 wks. annual holiday. Travelling allowance. Apply General Hospital, Bella Coola, B.C.

Instructor of Nurses. Gross salary: $195. **Night Supervisor.** Gross salary: $190 less $30 maintenance per mo. **Qualified Dietitian** for May 10. Gross salary: $180. 188-bed hospital. 44-hr. wk. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150. and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Supt. for 20-bed hospital. Some obstetrical experience necessary. Apply, stating age, experience, qualifications, to Dr. D. H. Dixon, 78 Dundas St., Oakville, Ont.

Supt. to take complete charge of 50-bed General Hospital with School for Nurses. Apply, giving full details of education, post-graduate training, experience & references, to sec., Board of Trustees, Miramichi Hospital, Newcastle, N.B.

Operating-Room Supervisor & Nursing Arts Instructor. Immediate opening. Good location. State Capitol with many civic advantages. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Registered Dietitian to take full charge of dietetics, food purchases, etc. Position requires supervision of all housekeeping & service staff in 85-bed hospital. New hospital proposed in 1949 which will require person capable of assisting with plans, etc. Apply Matron, West Coast Hospital, Port Alberni, Vancouver Is., B.C.

Vancouver General Hospital has positions vacant for **General Staff Nurses.** Salary: $155 (plus laundry) increasing to maximum, $185. Extra $5.00 all-night rotation shifts. 4 wks' vacation & 11 statutory holidays with salary. Superannuation. Sick leave allowances. Registration in British Columbia essential. Apply Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Graduate Nurses for General Duty. Salary: $155. Straight 8-hr. duty, 4 wks. annual vacation, 9 statutory holidays. Good living accommodation. Cafeteria meal service. Apply Matron, West Coast Hospital, Port Alberni, Vancouver Is., B.C.

Graduate Nurses for completely modern West Coast hospital. All-graduate staff. Commencing salary: $160 per mo. less $25 for board, residence, laundry. Annual increment, 44-hr. wk. 1 mo. vacation with pay after 1 yr. service. Transportation allowance not exceeding $60 refunded at end of 12 mos. Apply, stating experience. Matron, General Hospital, Prince Rupert, B.C.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan, 3 wks. holiday after 1 yr. service. Apply.Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Graduate Nurse for General Floor Duty. Salary: $110 monthly. Full maintenance & laundry. Blue Cross hospitalization plan. $60 yearly increase up to 3 yrs. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Lady Supt. for 75-bed Chipman Memorial Hospital, St. Stephen, N.B. Apply, giving full particulars & for further information, to S. D. Granville, Sec.

Graduate Nurses (2) for General Duty immediately at R. W. Large Memorial Hospital of the United Church of Canada, located at Bella Bella on the B.C. coast, 300 miles north of Vancouver. Salary: $150 gross, less $25 per month for maintenance. Fare to hospital refunded after 1 yr. of service. Apply to Matron.

Supt. of Nurses for 40-bed modern General Hospital opening May. Qualified administrator with experience in hospital of similar size required. Duties to commence March 1. Private 3-room suite supplied. Apply, stating references, experience, qualifications, marital status, age, religion & include photo, to Sec., Queens General Hospital Ass'n, Liverpool, Queens Co., Nova Scotia.

Graduate Nurse as Asst. in Operating-Room. Good salary, commensurate with experience & ability. Apply Grace Dart Home Hospital, 6085 Sherbrooke St. E., Montreal 5, Que.

WANTED BY

• CANADIAN RED CROSS SOCIETY •

Director of Nursing Services for Nova Scotia Division—headquarters Halifax. Public Health Nursing experience preferred.

Registered Nurses for Outpost Services in Saskatchewan, Manitoba, New Brunswick, British Columbia, Nova Scotia, Ontario, and Quebec.

Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply **National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley Street, Toronto 5, Ontario.**

WANTED

at

THE GENERAL HOSPITAL OF PORT ARTHUR, ONTARIO, A SUPERINTENDENT OF NURSES

To be in complete charge of the Nursing Service, including Ward Aides and Orderlies, and to relieve the Superintendent. The hospital has 250 beds, a Training School of 42 students, an Instructor and Clinical Supervisor. The salary is open. Apply, stating qualifications, and experience, to Miss A. B. Hunter, Superintendent.

Positions Wanted

Obstetrical Supervisory Position. Day duty preferred. Post-graduate course & 1 yr. experience at Boston Lying-in Hospital. Available immediately. What offers? Apply c/o Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Laboratory Technician (experienced) desires position in hospital or clinic. Apply c/o Box 2, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Back Journals Available

Do you desire complete sets of the *Journal* from former years? The Canadian Nurses' Association has on hand complete sets for the years from 1934 to 1947. The only cost would be express charges for forwarding. Write to the association at *Suite 401, 1411 Crescent St., Montreal 25, Que.*

WANTED

Applications are invited for the following positions:

Nursing Supervisor
(4 positions open)
Salary: $160 per month plus Bonus

Charge Nurse
(3 positions open)
Salary: $150 per month plus Bonus

at

Clearwater Lake Indian Hospital, The Pas, Manitoba.

Board, Room, and Laundry supplied at $25 per month. 4 weeks' holidays with pay annually. Pension Plan available and other privileges. Transportation arranged. Tuberculosis Nursing experience preferable but not essential.

Apply to: **Secretary-Treasurer, Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg.**

SCHOLARSHIP AWARD

The Alumnae Association of the **Kingston General Hospital** is pleased to announce that a Scholarship will be awarded this year, covering $500, to a member who has had at least one year's experience and who wishes to do post-graduate study.

Please state course desired and make application to:

Miss Hope Carnegie, Sec.
Nurses' Alumnae,
General Hospital,
Kingston, Ontario.

Note that applications will be received until *April 30, 1949.*